

SCOTTISH HOME AND HEALTH DEPARTMENT

# ***Suggestions and Complaints in Hospitals***

*Report of the Working Party*



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## CHAPTER 1

### Introduction

1. We were appointed as a working party in May 1966 by the Secretary of State for Scotland in accordance with a recommendation of the report of the Committee of the Scottish Health Services Council entitled "Administrative Practice of Hospital Boards in Scotland" (Farquharson-Lang report).<sup>1</sup>

2. The Farquharson-Lang committee reviewed the existing arrangements for the handling of patients' suggestions and complaints primarily in relation to the responsibility of boards for the oversight of patient care and for acting as "consumer councils". They concluded that ordinarily there was no recognised channel known to patients or relatives for making complaints, or for further representations if there was dissatisfaction with any action taken; nor were there any similar recognised arrangements for receiving suggestions from patients. They agreed that since the hospital service was a public service there ought to be a channel known to patients and relatives, as well as to the internal administration, through which the public could make suggestions or complaints.

3. The recommendations of the Farquharson-Lang committee in this connection were that:

- (a) all boards should be required to institute a recognised procedure, known to patients and relatives, for the handling of complaints and suggestions;
- (b) a working party should be appointed to devise such a procedure;
- (c) boards should obtain regular reports on complaints with the aims of ensuring that complaints were being dealt with effectively and ascertaining in what respects the services provided were not meeting the needs of patients collectively, so that remedial action could be taken.

The full text of the relevant paragraphs (paras. 143-147) from the Farquharson-Lang report is contained in Appendix I.

4. Accordingly, we regarded our general terms of reference as being "to devise a procedure, known to patients and relatives, for the handling of complaints and suggestions in hospital" and defined our task in more detail as follows:

- (a) to devise a procedure (or procedures) for dealing with all types of suggestions or complaints, ranging from the most trivial to the most serious, from patients or from relatives or friends on behalf of patients;
- (b) to devise a procedure (or procedures) to cover in-patients, out-patients and relatives or friends acting on behalf of patients at all types and sizes of hospitals and in all specialties;
- (c) to devise a method of publicising among patients, relatives and friends acting on behalf of patients this procedure (or procedures) including the kind of appeal which might be made;
- (d) in developing a procedure (or procedures) to take account of the interests of both the patient and of hospital staff;

(1) "Administrative Practice of Hospital Boards in Scotland"; Report by a Committee of the Scottish Health Services Council (H.M.S.O. 1966).

- (e) to recommend methods whereby boards could obtain regular reports on suggestions and complaints and to consider the use to be made of these reports.

In amplification of (d), we have throughout our discussions regarded it as of the greatest importance to ensure that any steps taken to protect the interests of patients do not place an unreasonable burden on hospital staff or have a harmful effect on their interests. At one stage, we planned a separate chapter on this theme, but as we worked through our subject in more detail we found that the theme had to be kept in mind the whole time and thought it better to consider it in each chapter rather than concentrate on it in a separate chapter. We do attach so much importance to this aspect, however, that we think it necessary to emphasise it right at the beginning of our report and to include it specifically in the definition of our task.

5. At an early stage in our deliberations, we agreed that it would be wrong either to place, or to be thought to be placing, undue emphasis on complaints. This point was subsequently supported by many of the people giving evidence. For these reasons, we decided to refer in our own discussions or in discussion with witnesses to "suggestions and complaints" in that order, thus departing from the order of words in the Farquharson-Lang report.

6. We also agreed that it was necessary to define a number of terms as they are used by us in our report. These terms as used by us are abbreviations for cumbersome phrases which would be tedious if repeated throughout.

*Comments* We have used the neutral word "comments" except in instances where "suggestions" or "complaints" or some other term is more appropriate.

*Patients* We have used the term "patients" to cover relatives and friends except in instances where the particular aspect of the subject being discussed requires otherwise.

*Sister* We have used the term "sister" to cover ward and departmental sisters and charge nurses except in instances where some other term seems more suitable.

*Matron* We have used the term "matron" to cover "principal nursing officer" and other senior nursing staff.

*Medical Superintendent* We have used the term "medical superintendent" to cover both medical superintendents and physician superintendents.

*Procedure* Some people have suggested that there ought to be a single procedure applicable in all circumstances, while others would like a number of procedures related to the type of comment and the type of hospital. Unless the context otherwise requires, we have used the singular throughout without prejudice to our later recommendations on this subject.

7. It was brought to our attention that a hospital memorandum (reproduced in Appendix II) entitled "Methods of Dealing with Complaints by Patients", had been issued by the Minister of Health on 7th March, 1966, to all regional hospital boards, hospital management committees and boards of governors in England and Wales.<sup>1</sup> This memorandum did not cover the whole width of our remit; for instance, it did not deal fully with subjects like the method of publicising the procedure to patients, although it did outline in some detail the procedure

(1) H.M. (66) 15.

for dealing with complaints of a serious nature, or those which could not be dealt with satisfactorily at local level. There are obvious advantages in having matching procedures in Scotland and in England and Wales and we have taken full account of the memorandum in places where its provisions run parallel to our remit.

8. One of our first tasks was to decide whether evidence was to be taken, and if so, to what extent. A minority of our members was initially of the opinion that our task could be completed quickly and simply by the introduction of a procedure which ensured that as many comments as possible were dealt with at hospital level. Against this suggestion it was argued that such a course was based on an over-simplification of the present situation and on assumptions of which we had no objective proof; that such a procedure could not cope with complaints of a serious nature; and that our recommendations would be more acceptable if based on fact. We agreed therefore that factual evidence should be sought about the existing situation, and views invited on possible procedures. Evidence had therefore to be sought from various sources, such as hospital authorities (both members and officers), hospital staff, organisations representing staff interests, patients, and the general public.

9. We first invited every board of management in Scotland to provide information in the following terms:

“(a) what documents are in existence giving information to patients entering or about to enter hospital, to out-patients and to relatives of patients; and in particular, what reference is made in these documents to suggestions or complaints which a patient or relative may wish to make (boards are invited to submit samples of all these documents);

(b) what oral information is given to in-patients, out-patients, and patients' relatives regarding opportunities for making suggestions or complaints;

(c) what formal procedures have been adopted for dealing with suggestions and complaints from in-patients, out-patients and patients' relatives at board of management level, hospital level and ward or departmental level;

(d) what records of suggestions and complaints are kept at each of the three levels, and if records are kept, how many suggestions or complaints have been recorded annually since January, 1964 and what are the main categories;

(e) what local associations (e.g. “League of Friends”, and other voluntary organisations) concerned with the welfare of patients are attached to the hospitals in the group.”

In all, sixty-five boards of management provided us with information, a most gratifying response to our invitation.

10. In addition, every board of management and every regional hospital board in Scotland was invited to submit to us their views on our remit. A substantial majority of boards of management and all five regional hospital boards submitted views all of which have been of great assistance to us.

11. A wide cross-section of individuals and organisations representing the other interests mentioned in paragraph 8 was invited to submit written evidence in the form of views on our remit. The response was generally excellent and of very great value to us.

12. We also decided that a general invitation should be issued to any person or organisation to make their views known to us. This invitation was made in the form of a press release on 12th September, 1966 to the national daily press and to medical, nursing and midwifery journals, announcing the setting up of the working party, our aims, and our readiness to receive any views. This press release produced three letters; two letters were not relevant to the business of the working party, but the third did bring to our notice the particular difficulties of one group of patients.

13. We agreed that oral evidence would be necessary to supplement the written evidence we had received and to obtain the views of certain individuals and organisations who could, we thought, best be approached in this way. In all, nine boards of management (selected by ourselves), four regional hospital boards, seven individuals and fourteen groups of representatives of organisations gave oral evidence. A list of those giving written and oral evidence is contained in Appendix III.

14. It soon became evident to us that the patients' point of view was not going to be adequately represented in our evidence. We were aware that in recent years several publications concerning patients' reactions to hospital treatment had been made in England and Wales, and in Scotland, including:

"The Hospital Service II—The Patient is Human" (1950), P.E.P.

"Suggestions Patients Make" (1954) Portsmouth H.M.C., *The Hospital*

"The Patient's View of the Hospital" (1961) Haywood & Others, *The Hospital*

"The Patient's Attitude to Nursing Care" (1961) Anne McGhee, E. & S. Livingstone

"What's Wrong with Hospitals?" (1964) Gerda Cohen, Penguin

"Human Relations and Hospital Care" (1964) Anne Cartwright, Institute of Community Studies, Routledge and Kegan Paul

"People in Hospitals" Elizabeth Barns, MacMillan & Co. Ltd.

"If I Could Alter One Thing . . ." (1965) Winifred Raphael, *Mental Health*

"The Edinburgh Out-Patient Enquiry" (1966), Scott & Gilmore

"Aspects of Patient Care: An enquiry into the methods of handling suggestions, comments or complaints made by or on behalf of patients" (1968), Oxford Regional Hospital Board.

These studies have provided a considerable amount of information about the content of patients' comments and we considered that it would not be necessary to carry out any further study dealing primarily with this aspect of the subject.

15. What was still lacking was information about the various circumstances affecting the making of comments. We therefore requested the Research and Intelligence Unit of the Scottish Home and Health Department to carry out an inquiry among all types of patients in all types of hospitals in Scotland. The specific areas which we requested the Research and Intelligence Unit to study from the patient's viewpoint were:

- (a) the degrees of willingness of various types of patient to make comments;
- (b) the availability of convenient means of making comments;

- (c) the ways in which, and the staff to whom, comments are actually made;
- (d) the action taken to deal with these comments.

16. The inquiry by the Research and Intelligence Unit was carried out simultaneously with our taking oral evidence. The results proved to be so comprehensive and valuable, not only for our purposes but for the hospital service in general, that they are to be published separately. A brief account of the purpose and methods of the inquiry is contained in Appendix IV. A full report of the inquiry will be produced subsequently by the Research and Intelligence Unit.

17. The acquisition of so much evidence from so many sources has to a large extent dictated the form of the report and the layout of the individual chapters. We felt it important clearly to distinguish factual information (including information coming from the inquiry by the Research and Intelligence Unit), views expressed by our witnesses, and our own views, and each chapter of the report has to the appropriate extent been divided accordingly.

18. We held our first meeting on 12th September, 1966 and in all we have held 19 meetings.

19. At a very late stage in our discussions, Dr D. H. Smith, Physician Superintendent, Ashludie Hospital, Monifieth, resigned from the working party because of ill-health. We were very sorry indeed to lose the benefit of Dr Smith's wide experience, but we have tried during the final stages of our work to keep in mind the points he made at the meetings at which he was present before his resignation. Just as we were completing our report, we were most distressed to hear of the sudden death of Miss M. Macnaughton, the Chief Nursing Officer of the Scottish Home and Health Department, who was one of our assessors. Throughout our proceedings Miss Macnaughton had been tireless in the help she gave us and in drawing to our attention the particular problems of the nursing profession in our field of review.

20. We wish to express our gratitude to all those who gave evidence, both written and oral. In addition, we wish to record our great appreciation of the assistance given by Dr M. A. Heasman, Mrs V. Carstairs, Miss A. Skrimshire, Miss M. Smithers and Mrs P. Thistlethwaite of the Research and Intelligence Unit. Our deepest debt of gratitude is to our secretary, Mr I. G. Dorward, formerly the Hospital Secretary of the Simpson Memorial Maternity Pavilion and now Principal Administrative Assistant with the Board of Management for West Lothian (Bangour) Hospitals. Mr Dorward has had an immense task in making all the arrangements for our meetings and for the hearing of evidence, in guiding our discussions and in producing our report. Throughout our proceedings he has shown the greatest energy, enthusiasm and efficiency and we are most grateful to him for all that he has done. We could not have had a more efficient secretary. In thanking Mr Dorward we should like also to thank the South-Eastern Regional Hospital Board, the Board of Management for the Royal Infirmary of Edinburgh and Associated Hospitals and the Board of Management for the West Lothian Hospitals for making his services available to us.

## Terminology and Classification

### Present Situation

21. Although the terminology used in the Farquharson-Lang report and in our remit is "complaints and suggestions", there is a whole range of words and phrases in general use in the hospital service to cover either a part, or the whole of the meaning of these two words. These include such words and phrases as "suggestions for improvement", "criticism", "dissatisfaction", "difficulties", "comments", "constructive comments", "observations", "matters causing discomfort" and "queries". Different witnesses favoured the use of some of these words and phrases in preference to others for largely subjective reasons. But as witnesses pointed out, there is great difficulty in defining these terms and in determining the difference between them in a way that both patients and staff would understand. Our area of consideration covers all the words and phrases in general use in the hospital service to cover either the whole or part of the meaning of the phrase "suggestions and complaints".

22. Again there is no general accepted classification either in relation to the subject of the comment or in relation to its importance. In the first case, it may not be clear whether a comment is concerned with medical care, nursing care, administrative matters, standards of accommodation, or a combination of these. In the second case, there is the widest variation from minor suggestions about shutting a window to major complaints which could lead to legal action.

23. It is not surprising that this confused situation exists; and it would be unrealistic for us to make firm recommendations about terminology. We accept that this confusion exists and take it into account in devising a procedure.

### Views Taken in Evidence

24. The complexity of terminology is illustrated by the varying views presented to us about the use of words and phrases in devising and publicising a procedure. Some witnesses expressed the opinion that the use of the word "complaint" would lead to the hospital service being swamped by the response from patients, and to the morale of staff being seriously undermined; on no account should the word "complaint" be used, but if it were, it should not be emphasised in any way. Other witnesses said that to avoid the word was not facing up to the truth of the situation. In this connection, we were interested to note that one board of management had substituted the word "complaint" for "suggestions for improvement in the service" in an information booklet for patients in one hospital in the group, but this had created no difference between the response from patients in that hospital and other hospitals in the group.

25. The alternative to "complaints" most commonly put forward was "suggestions for improvement" or slight variations of this phrase. Other alternatives were those mentioned in paragraph 21 with "comments" the next most popular choice.

26. Various classifications of comments were suggested to us, for example:

- (a) trivial, frivolous and serious;

- (b) criticisms (constructive or otherwise); complaints, suggestions for improvement;
- (c) administrative and domestic; partly administrative and partly medical; medical and nursing care;
- (d) medical; nursing; food;
- (e) faults in the system; accommodation; lack of information;
- (f) requests for corrective action; minor complaints; serious complaints; constructive suggestions;
- (g) medical; nursing; lay.

### **Evidence from the Inquiry**

27. In the course of the inquiry, in-patients were asked whether there was any aspect of hospital life which had dissatisfied or displeased them, or whether they had any suggestions for improvement. A classification scheme was devised which was based on the content of the comments made. Comments fell very largely in areas relating to the physical environment and to the social environment and ward routine (these together accounted for 68 per cent of topics mentioned in general hospitals). Comments about staff were classified into matters relating to attitude, skill, and attention and availability (these together accounted for slightly more than 20 per cent of topics, attention and availability attracting more comment than attitude or skill). The range of topics mentioned by patients in mental and mental deficiency hospitals showed much the same pattern, although slightly less emphasis was given to physical environment and some additional topics appeared, such as patients' allowances and detention in hospital. The importance of individual topics within these broad groups was particularly interesting. Food was most frequently mentioned both as a ground of dissatisfaction and satisfaction. Other matters of dissatisfaction, in order of frequency, were: accommodation, ward routine, amenities, visiting, comfort, information, disturbance from other patients, staffing shortage and ward regulations. In mental and mental deficiency hospitals, disturbance from other patients ranked third in this list. Of the ten topics most frequently raised in general hospitals, only two (information and staffing shortage) are to be found outside the areas of physical and social environment.

28. The inquiry did attempt to get patients to grade their comments according to importance, but it was quite apparent that there was no comparability in the response of patients owing to lack of an objective scale of importance. It became clear to research staff that there was no method in which they themselves could classify comments on this basis, as importance of the comment to the patient was subjectively determined, and often bore little relation to what might be considered of importance by the hospital in the context of good patient care. No analysis was therefore made on this basis.

29. Other inquiries, notably those by Cartwright, McGhee, and Raphael (listed in paragraph 14) have also produced lists of matters which cause dissatisfaction. Because of differences in the population under consideration, and of the methods of these inquiries, the findings are not strictly comparable and the range of topics and the emphasis placed on them does vary. Taken together these studies do not suggest that there is necessarily any consistency throughout the country on matters causing dissatisfaction to hospital patients; the substance

of such dissatisfaction may well vary from time to time from one hospital to another according to length of stay, age, social class and numerous other factors both definite and indefinite. What the studies do make clear is that some level of dissatisfaction could be seen to exist in all the hospitals reviewed in them.

30. Out-patients were asked whether there was any particular aspect of their visits to out-patient departments which had dissatisfied them. Of the comments received, 70 per cent concerned physical environment, and social environment and routine. The topic most frequently mentioned was waiting time at the clinic; approximately one-quarter of the out-patients seen mentioned this point. Accommodation (e.g. waiting space and lavatories) ranked second, and amenities (e.g. canteen facilities and reading materials) third. Comments about transport to hospital and about comfort ranked joint forth, being mentioned by five per cent of patients in each case.

### Our Views

31. Use of the word "complaint" is unavoidable; complaints do occur and this fact has to be faced. A number of hospitals are at present using this word in information booklets without any apparent problems and we cannot believe that the use of the word would in itself lead to an outbreak of trivial or malicious complaints. But we do agree that "complaint" should not be unduly emphasised, and we recommend that the words should be used together with "suggestions" in the form "suggestions and complaints"; this phrase draws the correct balance between the positive nature of "suggestions" and the more negative word "complaints", and seems to cover adequately the sense of all the words and phrases mentioned in paragraph 21. The phrase "suggestions and complaints" should therefore be used in preference to any one or any combination of these words and phrases.

32. As far as classification is concerned, the main problem is to devise a system which leads to the minimum amount of overlap between the various types of comments. Difficulties are most likely to occur when there is an attempt to classify by headings such as "medical matters", "nursing matters" and "administrative matters" since these are not precisely definable terms.

33. We do not think that any formal classification by subject is necessary but, in so far as it might be convenient to classify for record purposes, we favour a system on the lines of the one used by the Research and Intelligence Unit. On this basis, comments would be divided into the following five groups:

- (a) physical environment;
- (b) social environment and routine;
- (c) staff attitudes, skill, attention and availability;
- (d) information and communications;
- (e) other.

34. We considered whether these groups should be further sub-divided on the basis of an initial assessment of the seriousness of the comment, but we doubt whether this is desirable since the importance attached to a comment is largely a matter of subjective judgment. The procedure suggested in our report would lead to subdivision according to the levels at which comments are handled.

## The Necessity for Having a Procedure Known to Patients

35. The factual information provided by boards of management shows that there is an accepted procedure for dealing with comments at 25 hospital groups, but in only four cases is this procedure committed to writing. The majority of boards of management provide information booklets for patients but only in 18 groups do these booklets contain a paragraph telling patients what to do if they have any comments.

### Views Taken in Evidence

36. We asked all witnesses giving oral evidence whether they considered it was necessary to have a procedure known to patients. Only a very few considered that it would be detrimental to introduce a procedure for dealing with comments and to publicise this procedure. The kind of reasons given for not introducing a procedure were: the incidence of comments does not justify a procedure; there are very few patients who do not know how, or would not find a way to complain if the need arose; and a procedure would by its existence lead to an increase in the number of comments, to unrest and dissatisfaction, and to a deterioration in staff morale.

37. Most representatives of hospital authorities in rural areas thought that there was no need for a procedure in small hospitals in rural areas because patients did not complain. One such board of management reported that it had had no complaints in twenty years, and one board had had only one in the same period. The explanation given was that the size of these hospitals led to a close relationship between staff and patients and the size of the community led to a real personal knowledge of the hospital among the local population.

38. A larger proportion of witnesses viewed the introduction of a procedure with certain reservations. While accepting that facilities ought to exist to cover genuine cases, they saw the introduction of a formal procedure as an open invitation to patients to complain, and feared an increase in the number of trivial and malicious complaints. It was questionable whether the advantages of having a well-known procedure, which should increase the prospects of genuine comments being made, would outweigh the disadvantages of a number of trivial complaints. These witnesses therefore favoured having a simple procedure for dealing with comments which could be introduced informally to suit local arrangements. It was also suggested that the need for a procedure for dealing with comments in general hospitals would be diminished if there was consultation between staff and patients, giving opportunities for free exchange of ideas. We also noted that a recent report<sup>(1)</sup> recommended the establishment of a Community Service Patients' Advisory Committee.

39. It was generally felt that the position of mental and mental deficiency hospitals was different to that of other hospitals. In mental hospitals, the existence of the therapeutic community, where the relationship between staff and patients was less formal, and where there was ample opportunity in discussion

(1) "The Shape of Hospital Management in 1980?" King Edward's Hospital Fund for London, 1967.

for free exchange of ideas, should diminish or eliminate the need for a procedure for dealing with comments. Patients in mental deficiency hospitals were in a very different category from others, and these hospitals constituted a special problem, with the relatives of patients being of greater significance in this context than the patients themselves.

40. The most important distinction with regard to mental and mental deficiency hospitals in Scotland was the role played by the Mental Welfare Commission. This was pointed out to us by authorities from these hospitals and by the Mental Welfare Commission itself. The Commission was established by the Mental Health (Scotland) Act 1960, as an independent body with the duty of exercising protective functions in respect of persons who might, by reason of mental disorder, be incapable of protecting their own interests adequately. In the exercise of these functions, the Commission had the duty of making regular visits to patients who were liable to be detained in hospital under the Act and of giving them the opportunity to request a private interview. When visiting these patients, the Commission must also give the opportunity of a private interview to any other patient in the same hospital (i.e. patient resident on an informal basis) who requested it. The Commission's duty in this respect was carried out mainly by their full-time medical commissioners to whom the patients might make any complaints when interviewed. Complaints might also be made direct to the Commission by patients, relatives or other interested parties. In addition, the Commission had the duty to enquire into any case where it appeared to them that there might be ill-treatment, lack of care or treatment, or improper detention of any person who might be suffering from mental disorder, and also to enquire into any case where the property of such a person might be exposed to loss or damage. Where they consider that remedial action was called for, they were required to bring the facts of the case to the notice of the relevant board of management and in appropriate cases to the Secretary of State. The Commission had the power to discharge a patient who had been compulsorily detained.

41. The Commission considered that whatever procedure might be introduced, it must continue to be open to patients or relatives to raise the matter with the Commission either initially or if dissatisfied with the action taken by the hospital authorities. The hospital authorities concerned agreed with this and some considered there was no need, because of the existence of the Commission, to introduce an alternative procedure for dealing with comments in mental or mental deficiency hospitals.

42. As far as out-patients were concerned, a number of witnesses stressed that it was particularly necessary to introduce a procedure because out-patient departments generally gave the greatest cause for complaint, and because out-patients at present were given very little, if any, information about how to make comments. One witness brought particularly to our attention the difficulty confronting patients attending venereal diseases clinics in making complaints about mismanagement or mishandling by staff within the clinic. Such patients, it was claimed, did not dare complain to the clinician in charge and were afraid to complain to anyone outside the clinic because by doing so they automatically admitted having attended a venereal diseases clinic and so suffered social stigma. Another witness on this subject, however, felt that if a venereology department were well run with regard to the legal and ethical rights of a patient, no difficulties should arise, and the introduction of a special procedure for such patients might create problems which did not exist at present.

43. Most witnesses thought that the present informal and varying arrangements did lead to a risk that real complaints might be overlooked and felt that a more formal procedure should be introduced and should be made known to patients. There should be, as far as possible, one basic procedure for all types and sizes of hospitals though it might require to be modified for smaller hospitals and certain special types of hospitals. This made it most important that the basic procedure should be simple and flexible.

### Evidence from the Inquiry

44. It was apparent that the reasons given by patients for not making or discussing comments with staff to a greater extent were various and complex, and depended on such things as the patients' assessment of the matter, the patients' assessment of their role in making comments, personality factors, ignorance of the procedures for making comments, consideration for others, pessimism and anxiety. The suggestion that a procedure known to patients would encourage more trivial complaints (para. 38) did not seem to be borne out by the findings. Patients who had received information booklets did in fact make rather more comments to the interviewers than those who had not (on average each patient who had received an information booklet made 1.6 comments, while each of these who had not made 1.2), but these differences could have occurred by chance. Contrary to expectation, patients who had received information booklets showed no greater inclination to discuss the matter with staff, and a smaller percentage had done so (37 per cent) than was the case for the remainder of patients (44 per cent). Again these findings were not statistically significant. This suggests that no true differences can be seen between patients grouped according to whether they had or had not received information on the channels of complaint, in respect of the volume of critical comment made by them, and their willingness to discuss suggestions and complaints with the staff. Evidence from the inquiry tended to substantiate the views put forward by witnesses relating to communication between staff and patients in mental hospitals (para. 39). Over 60 per cent of patients in mental hospitals said they had discussed a comment with staff, compared with over 40 per cent of in-patients and only 15 per cent of out-patients in general hospitals.

45. In-patients were asked if they thought that there were adequate arrangements to allow them to comment on matters of concern to them. Sixty-five per cent considered the present arrangements were adequate and 19 per cent thought they were not. This is not as significant as the figures might suggest; "Yes, I suppose so" was not an uncommon answer from individual patients. The difference in response between patients grouped according to whether they had any comments and whether they had discussed any matter with the staff was interesting, as is shown in the following table for in-patients in general hospitals:

| <i>Category of patient</i>                                            | <i>Proportion of these patients who considered arrangements inadequate</i> |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------|
| Patients who had had no comments to make                              | 8.4%                                                                       |
| Patients who had had comments to make but had taken no action on them | 18.6%                                                                      |
| Patients who had had comments to make and had taken action on them    | 34.5%                                                                      |

These statistics suggested that patients who had tried to use the existing arrangements had found them inadequate.

46. Sixty per cent of out-patients interviewed thought that the present procedures for making comments were adequate, while 20 per cent thought they were not. Again, the response between different groups of patients suggested that those who had tried to use existing procedures had found them inadequate. The trends for mental hospitals and for out-patients followed a similar pattern, but the numbers involved were too small to show statistically significant differences.

### **Our Views**

47. Like the majority of our witnesses, we regard the present arrangements for dealing with comments as inadequate. In reaching this conclusion we are particularly influenced by the high proportion of dissatisfaction shown in the inquiry among those who had tried to use the present arrangements. However, we recognise that only 43 per cent of patients in the inquiry had discussed their comments with staff, and that the reasons for not doing so were various and complex.

48. We regard it as one of our fundamental objects to produce a procedure that is appropriate in all types of hospital even though this might mean changes in existing arrangements in some hospitals. We think this particularly important as patients may move from one hospital to another at different stages of an illness or have different illnesses, and staff too are likely to serve in different hospitals during their careers; it would be of great advantage to both patients and to staff if the procedure in all types of hospitals was on similar lines. The basic arrangements, therefore, should be sufficiently flexible to cover in-patients and out-patients in all types of hospital. This requires a simple and informal procedure for dealing with comments of a kind which can be handled to everyone's satisfaction at ward level, but a more precise and formal procedure for comments which cannot be dealt with satisfactorily in this way. With regard to rural hospitals, although we accept that it should be necessary to bring the procedure into operation only very infrequently, we recommend that our proposed procedure should apply in order to provide a consistency of approach in all hospitals.

49. In mental and mental deficiency hospitals, we do not think that our procedure need conflict in any way with the work of the Mental Welfare Commission. We envisage that the simple and informal part of our procedure will operate in mental and mental deficiency hospitals for handling those comments which can be dealt with satisfactorily at ward level and which would not normally come to the Commission's knowledge, although we think that the more serious cases should be referred to the Commission.

## Publicising the Procedure

### I. THE NEED TO PUBLICISE THE PROCEDURE

#### Views Taken in Evidence

50. There was general agreement among those witnesses who favoured the introduction of a procedure that it was essential that the procedure should be made known to all concerned.

#### Evidence from the Inquiry

51. In-patients were asked if they knew how a patient should make a comment. Although 72 per cent answered that they would talk to some specified person, 24 per cent said that they did not know what they should do. The proportion of those who did not know was considerably higher for women than for men (28 per cent as against 18 per cent), and for people over 65 compared with the younger age groups (31 per cent as against 20 per cent). Differences were also apparent between specialities; orthopaedic and maternity patients were the best informed and parents of children and geriatric patients were the least well informed. The most striking positive finding was that only 12 per cent of those patients who said they had received information booklets said that they "would not know what to do" compared with 27 per cent of those not receiving any information.

52. Out-patients were also asked if they knew how a comment about out-patient departments should be made. Forty-one per cent of patients interviewed said that they would not know what to do; this was a very much larger proportion than the corresponding one for in-patients (24 per cent). Women were less well informed than men, but in contrast to the in-patient situation, older age groups claimed greater knowledge than younger. Among out-patients, maternity patients and parents of children appeared to be least well informed about the arrangements.

#### Our Views

53. A large proportion of both in-patients and out-patients interviewed said they would not know what to do if they had a comment to make. These figures support the view of the majority of our witnesses that it is essential that the procedure should be publicised. We recommend that this should be done.

### II. METHOD OF PUBLICISING THE PROCEDURE

#### Present Situation

54. As previously mentioned, information booklets containing reference to the subject are supplied by 18 boards of management. In addition to this, seven boards indicated that oral information was given to patients. Although the content varies, it is the usual practice to invite suggestions for the benefit or improvement of the service. In most cases, patients are offered the option of speaking to someone or writing to one or more individuals, such as the medical

superintendent, the matron, the group or hospital secretary while in others there is no indication to whom comments should be addressed. In some cases it is stated that all comments should be in writing.

55. Most of the groups favouring oral information are responsible for mental hospitals where discussion groups or ward meetings are held regularly. In other such groups the matron or the sister tells patients about the procedure for making comments.

### Views Taken in Evidence

56. Three boards of management opposed written publicity, each giving a different reason for this view; one board (for a group of small rural hospitals) felt that in small hospitals the use of an information booklet would make staff/patient relationships less personal; another suggested that publicity would produce large numbers of comments, with the recipient of these comments being swamped by their volume; and a third argued that it was much more satisfactory for hospital staff to explain the procedure in person than for it to be put in writing.

57. A very large number of witnesses representing all interests considered that the principal method of making the procedure known should be by means of information booklets. Although most of them suggested other methods of publicity, one or two witnesses expressly stated that this should be the only form of publicity, since any other would give undue emphasis to the matter.

58. In discussing the kind of paragraph to be included in the booklet, many witnesses stressed the need for a balance between encouraging and discouraging comments. A standard paragraph would ensure a consistent approach throughout the country and some witnesses asked us to give guidance on the form of the paragraph. The paragraph, it was said, should have three purposes: first, to make the point that constructive comments were welcomed; secondly, to indicate the person to be approached; and thirdly, to give an alternative method of making the comment if the patient were dissatisfied with the results of the first approach. It was important that the paragraph should avoid confusing this procedure with other aspects of life in hospital, such as the discussion of medical problems with the doctor and personal problems with the medical social worker.

59. Other recommendations about the information booklet were that it should contain a description of the uniforms of the various grades of nursing staff so that they could be easily identified, and that the names of the senior officers, and even of board members, should be included.

60. Information booklets were generally felt to be less necessary for mental and mental deficiency hospitals particularly in the latter where booklets would be of little value for patients. We were interested to note that one large psychiatric hospital had stopped using information booklets because neither patients nor relatives showed interest in them; the type of information they had contained was now given verbally. The Mental Welfare Commission confirmed the impression that information booklets were uncommon in mental and mental deficiency hospitals, but suggested that they could be a useful method of making known the existence of the Commission.

61. In the case of out-patients, it was generally agreed that there should be a notice in each out-patient department or a paragraph on the back of appointment cards drawing attention to the procedure, though some witnesses thought that either of these methods would unduly emphasise the matter, and would encourage patients to make trivial comments. As an alternative, a number of witnesses thought that information booklets themselves should be made available in out-patient departments.

62. One or two witnesses pointed out that these methods of publicity were inappropriate to the patient admitted in emergency. To meet this need and to cover those who did not read the booklet, it was suggested that it might be the duty of a receptionist in an out-patient department or a ward clerk to inform all patients about the procedure.

63. Two other methods of publicising the procedure were suggested to us. First, a national publicity campaign was recommended by one witness; secondly, it was suggested that more could be done by information officers in the hospital service.

### **Evidence from the Inquiry**

64. Patients interviewed in hospitals which issued booklets specifying the procedure for making comments were asked if they had received a copy of the information booklet. Of the 246 patients concerned, 167 (68 per cent) said that they had not received a booklet or that they did not remember receiving one. Of the 79 who remembered receiving the booklet, 58 had received it before admission and 21 after admission. These figures suggest that some hospitals may be failing to ensure distribution of their booklet to all patients.

65. Of the 79 patients who remembered receiving a booklet, 10 said that they had not read it at any time. Of the 58 patients who received a booklet before admission, only 27 had the booklet with them in hospital, and of these only 15 had looked at it after admission. These figures suggest that it might be more profitable to send patients admission details before admission, and to distribute fuller information about life in hospital after arrival.

### **Our Views**

66. We recommend that the policy of providing information booklets, which should include a paragraph concerning the procedure, should be extended as quickly as possible to all hospitals in the country.

67. Although evidence from the inquiry suggests that information should be provided at two stages (before and after admission), we do not think that the hospital service can be expected to go to the length of providing two separate documents. Information booklets should be sent to patients before admission to hospital and there should be prominently displayed on the cover of the booklet a request that the patient should bring the booklet with him when he comes to hospital. To cover the position of those who fail to do so, booklets should also be available in wards and dayrooms.

68. If circulated in this way, these booklets provide valuable information at the most appropriate time to the greatest proportion of hospital in-patients and seem ideally suited for publicising the procedure without undue emphasis

since this is only one of many aspects of hospital life about which information is provided. Moreover, if patients are provided with information about various aspects of hospital life, some complaints about lack of information might be avoided. It would be particularly useful if information booklets contained paragraphs about such matters as how to obtain interviews with members of the medical staff, ward routine, identification of staff, etc.

69. We suggest in Appendix V the kind of material that might be included in the paragraph dealing with suggestions and complaints. We do not think that the paragraph need be given particular emphasis in the booklet by, for example, putting it at the beginning or by printing it in heavier print than the rest of the booklet; but it should be preceded by a prominent heading "Suggestions and Complaints".

70. We recognise that a proportion of patients will not read information booklets. To encourage them to do so, booklets should be attractive, concise and easily readable; to achieve this, hospital authorities could with advantage consult experts in this field. In the case of mental deficiency, geriatric and children's hospitals, information booklets should be directed more towards relatives than patients. Booklets in mental and mental deficiency hospitals should contain reference to the role of the Mental Welfare Commission.

71. Until all hospitals produce such an information booklet for circulation to patients we recommend that those hospitals without an information booklet dealing with suggestions and complaints should provide information about the procedure on the back of the patient's admission card or on some other document issued to all patients, if necessary a document dealing specifically with the subject.

72. As regards out-patients, we recommend that the information should be given on the back of the patient's appointment card. We doubt whether it is necessary for full details of the procedure to be posted in out-patient departments, though we do consider that notices should be posted naming the person to whom comments should be made and drawing the attention of out-patients to the fact that details of the procedure are outlined on the back of the appointments card. This latter point would give sufficient immediate information to those people attending V.D. clinics or casualty departments for the first time without appointment cards. A sample of the kind of material which might be included on the back of the appointments card and on the notice is given in Appendix V.

73. For patients admitted in emergency, we recommend that a routine arrangement for providing information booklets should be introduced.

74. It is important that everyone should be given the opportunity of learning, either before or as soon as they enter hospitals as in-patients or out-patients that a procedure exists and what this procedure is. We regard the steps we recommend as being the minimum needed to ensure that this information reaches patients. In addition, although we do not favour a specific national publicity campaign we hope that our report, if published, will have the effect of bringing our recommendations to the attention of the general public.

## The Recording of Comments at Ward or Departmental Level

### Present Situation

75. It appears to be unusual for boards of management to lay down precise arrangements for the recording of comments at ward level, this in general being left to the discretion of the sister. We were, however, told about two systems for recording comments at this level which have recently been introduced.

76. At Falkirk and District Royal Infirmary, a special form on which patients' comments can be recorded was introduced in 1967 in all wards and departments. An insert is enclosed with the admission letter advising patients of the new system, and in out-patient departments notices are displayed on walls. These forms are available in any ward and department, and are completed by the patients themselves and signed. Patients are advised that they may send anything of a confidential nature direct to the group secretary. Normally the forms are passed to the sister or head of department, who either deals with the matter, or if this is not possible, passes the form to the group secretary.

77. In the Dykebar and Associated Hospitals group, a "Complaints and Suggestions Book" has been introduced in each ward for entering details of all comments no matter how trivial. These books are produced at the monthly meeting of each house committee, and on average six entries are reported each month.

### Views Taken in Evidence

78. All witnesses thought that some recording of comments was necessary, although a few considered that recording should be limited to serious cases. The majority thought that all comments should be recorded with the exception of the trivial or comments which could be satisfactorily dealt with immediately. Most witnesses agreed that the decision whether a comment was significant enough to merit recording should be left to the discretion of the ward sister. But others pointed out that a comment which appeared trivial to hospital staff was not necessarily trivial to the patient. Thus it was suggested by some witnesses that the patient should always retain the right to insist on a comment being recorded.

79. Representatives of the nursing profession were generally of the opinion that all comments, whether trivial or not, should be recorded. It was argued that if investigations had to be made at a later date, the recorded information would be available, and this would safeguard the interests of patients and staff.

80. Two other methods of recording comments were suggested in addition to those described in paras. 76 and 77. First, it was suggested that information booklets should contain a detachable page on which comments could be recorded, the page then being handed in or sent by post. Some argued, however, that this method would present a too ready invitation to patients to complain. Secondly, we were informed that in several hospitals, suggestion boxes, placed at strategic points but not necessarily in wards, were in use. Some witnesses thought that suggestion boxes would encourage anonymous comments in addition to trivial

and malicious ones, but evidence on this point was inconclusive. Finally, two boards of management stated that it was the practice to record patients' comments in their case records.

### **Evidence from the Inquiry**

81. In-patients were asked whether they would prefer to talk to someone about **complaints** or whether they would prefer to put them into writing. Eighty-one per cent of patients in general hospitals stated a preference for talking to someone; nine per cent said they would prefer to complain in writing (the remainder did not answer specifically saying that they would not complain under any circumstances, or that it would depend on the nature of the complaint). The reason most often given for preferring to talk to someone (40 per cent of reasons) was that this was the easiest form of expression. Three other types of reason were fairly equal in importance: personality reasons (e.g. "it's more open", "it gets it off your chest"); reasons to do with effectiveness (e.g. "it can't get lost", "there's more notice taken") reasons to do with the possibility of discussing the matter and getting a response. Persons who preferred writing on the other hand most often cited reasons to do with effectiveness or thought this method more appropriate or better as a channel to higher authority.

82. In-patients were also asked if they preferred to talk to someone about **suggestions**, or would prefer to put them into writing. Compared with the channels preferred for complaints, more patients (21 per cent) selected a written channel for making suggestions; 62 per cent said that they would prefer to talk to someone.

83. It was anticipated that patients would answer these particular questions within the context of the situation as they knew it, and that it would be difficult for many patients to imagine other possibilities. For this reason, patients were given a list of ways in which hospitals might find out from patients what they thought of their stay in hospital, and were asked which method they would prefer to use. The largest single group of patients chose "a special person patients could talk to" (43 per cent), but almost as many (39 per cent) selected a written channel.

84. Both for mental hospital patients and for out-patients, the great majority preferred to talk to someone about both suggestions and complaints, although as with in-patients, the proportion was lower for suggestions than for complaints. For out-patients, the reasons given for this preference were very similar to those given by in-patients, but there was some difference in emphasis for patients in mental hospitals.

85. When given a choice of four ways in which the hospital could be given written notice of a comment, by far the most popular was "a form which the patient can post back to the hospital" (chosen by 43 per cent of patients), followed by "a form to fill in and leave at the appointments desk" (chosen by 22 per cent). The response from patients in mental hospitals was very similar to that for in-patients.

### **Our Views**

86. Patients interviewed expressed such a definite preference for talking to someone that we think that this must be accepted as the general view; and we

recommend that patients should not normally be asked to write down their own comments unless they want to. We agree with the majority of opinion that comments should generally be recorded at ward or departmental level and that hospital staff should do this. However, there may be occasions when, because of the nature of the comment, it is desirable that the comment should be committed to writing immediately preferably by the patient or by someone on his behalf if the patient is unable to do so. In this situation, the patient should be requested to put the comment into writing, and at the same time, the comment should be recorded by the member of staff. These steps in the recording of comments are discussed in greater detail in Chapter 6.

87. It would be an unreasonable burden on hospital staff to ask them to record every comment, however trivial, made by every patient, and we recommend that discretion should be used in recording comments, but that where there is doubt, a record should be made. In making this recommendation, we realise that we have left a loophole in the procedure and it will be possible for comments, which may turn out to be serious, to go unrecorded. Nor can we deny the possibility of a comment going unrecorded in an attempt to suppress it and the excuse of triviality being used if the matter comes to light later. We consider, however, that it would be a heavy imposition on staff to insist on the recording of every minor comment and feel that such insistence might imply a lack of trust in staff discretion.

88. Nevertheless, the loophole remains and to close it, we recommend that, as well as the recording of comments at the discretion of hospital staff, the attention of every patient should be drawn to his right to insist upon a comment being recorded, or to communicate in writing with the hospital authority before or after discharge.

89. Comments should be recorded in a special book (referred to in this report as the "comments book") kept in each ward or department for the purpose. This record should be as simple as possible and might include the date, identification of the patient making the comment, information sufficient to identify the comment should there be future enquiries about it, and a note of the action taken. The entry should be signed by the person making it. The "comments book" should be open to inspection by senior medical, nursing and administrative staff, and entries should be submitted to the nominated recipient for written comments (para. 139) at regular intervals, both as a check that the book is being maintained and as a means of keeping records of comments. Hospitals may find it advantageous to use either loose-leaf books, or books with carbon copies, and to number the pages of those books, so that reports can be sent to the nominated recipient for written comments without removing the book itself from the ward. Senior nursing staff may also ask the sister to bring the book to meetings of nursing staff, and may make such arrangements as they think desirable to keep themselves informed about comments.

90. Although we do not regard either suggestion boxes or detachable pages in information booklets as a necessary part of the procedure we recommend, we should certainly not want to discourage hospitals which think these methods useful in addition to instituting the new procedure.

91. In mental and mental deficiency hospitals, comments may arise in the course of ward meetings or discussion groups. Unless there are objections on

clinical grounds, comments arising in these circumstances should be treated in the same way as comments arising in general hospitals and should, at the discretion of the ward staff, be recorded.

92. In the case of those venereal diseases clinics where confidentiality is maintained by the use of code numbers, we recommend that these code numbers be recorded in the "comments book" in place of patients' names and addresses. This fact should be made known to the patients using these clinics to obviate any reluctance to make comments.

## CHAPTER 6

### The First Recipient of Oral Comments

#### Present Position

93. Although records are not generally kept and although there is no uniformity of practice in the hospital service, in very many instances the sister is the first person to whom oral comments are directed. But in addition comments about the service may be made orally to a wide variety of hospital staff and people outside the service; examples given to us included student nurses, domestic staff, doctors, chaplains, general practitioners (particularly in the case of small hospitals), regional board and board of management members, matrons, medical superintendents, hospital secretaries and voluntary workers.

94. Some comments are committed to writing without first being made orally to any person in the hospital. Written comments are sent to a variety of people including matrons, medical superintendents, hospital secretaries, group secretaries, regional board secretaries, Members of Parliament and the Secretary of State.

#### Views Taken in Evidence

95. The majority of witnesses considered that the person to whom comments should first be made by in-patients was the sister, because she was the person most closely and immediately concerned with the welfare of the patients and the person responsible for the administration of the ward. These were, however, the reasons given by other witnesses for the sister *not* being the first recipient of comments. It was argued that some sisters might take a defensive attitude or regard comments as personal criticism and might react in some way detrimental to the well-being of the patient. And if this did not in fact happen, fear of it could be a factor in making patients reluctant to make comments of any sort to the sister.

96. Some witnesses suggested that other members of hospital staff should be the first recipients of comments. Among these were junior doctors, junior ward staff (on the grounds that patients found them more approachable and preferred to speak to them), medical superintendents and medical social workers.

Medical social workers were apparently chosen because they were seen by some witnesses as being detached from the nursing and medical care of patients, and yet concerned with their welfare. It was, however, pointed out by other witnesses that this was not the role intended for medical social workers, that there were too few of them to undertake such duties, that if asked to carry out these duties they would lose the confidence of both staff and patients and that they could do very little other than pass on the comments they received.

97. Some witnesses from outside the hospital service were strongly in favour of a recipient who was completely independent of the hospital service, and could therefore deal with comments impartially. Patients, being aware of this impartiality, would therefore be much more willing to express themselves. The description given to a person was "reporting officer", "liaison officer" and "ombudsman". The use of the last title indicates a source of some confusion among our witnesses in relation to the function of an independent person. Some saw him as the person who received all comments; others regarded him as a final court of appeal when all other channels had failed. To try and avoid this confusion we intend to use the phrase "reporting officer" in connection with the first function and "commissioner" in connection with the second. In this chapter we concentrate on the concept of the "reporting officer".

98. Some witnesses representing hospital authorities and staff were opposed to the appointment of a reporting officer. It was said that he could do nothing more than pass on comments to some member of the hospital staff; that he would be regarded by hospital staff as an interferer whose existence would be unacceptable; that the position of the sister would be drastically altered for the worse; that the reporting officer would have less personal contact with patients than hospital staff, and for that reason patients would be reluctant to make comments to him and finally, that he would make the procedure unnecessarily complicated and formal. The question of the number of reporting officers required was also raised; ideally there would have to be a reporting officer on duty in every hospital twenty-four hours per day to be available to hear comments as they arose.

99. With regard to out-patients and casualties, it was suggested that the receptionist or the sister in charge of the department should receive oral comments. Witnesses in favour of reporting officers pointed out their possible value in out-patient departments, and some witnesses against the use of such persons for in-patients thought that there was a case for them in out-patient departments.

100. In the case of venereal diseases clinics, the suggestion was made that "pastoral visitors" should be the recipients for patients' comments. These "pastoral visitors" might be retired doctors of eminence whom patients would trust because of their eminence, lack of direct connection with the clinic, and the time and sympathy they would have for dealing with comments.

101. Another suggestion was that large general hospitals should each have an adequately identified information centre, sited in a central and accessible place and staffed by people with a thorough knowledge of the hospital service; the centre would provide information and guidance to out-patients and visitors, but should, in addition be a place where comments could be made and help given in writing them although investigation should not be undertaken by the staff of the centre.

## Evidence from the Inquiry

102. Patients who said that they would prefer to talk to someone about their comments were asked about the qualities of the person to whom they would like to talk. Some patients answered this question by defining qualities, others by naming a member of staff. Of staff members, the sister or someone on the ward was mentioned most often, (41 per cent of the total response). Matron was mentioned by 14 per cent, followed by the doctor, social worker, nurse, medical superintendent or hospital secretary, board of management and general practitioner in descending order of frequency. With regard to the type of person, "sympathetic, understanding and approachable" were the qualities mentioned by the largest proportion of patients (12 per cent); "someone specifically for the job", "someone independent of the ward" and "someone outside the hospital" were each mentioned by less than three per cent of patients.

103. Out-patients were asked the same question, and there was similar doubt about whether it meant naming a member of staff or defining qualities. The member of staff preferred by most patients was the doctor, followed by the sister. Others mentioned, but by a small number of patients, were administrators, matron, social worker, receptionist, general practitioner, nurse, board of management and regional hospital board. The type of person preferred most often was someone in the hospital with "knowledge and authority". Very few patients mentioned "someone specifically for the job" or "outside the hospital".

## Our Views

104. The results of the inquiry do not seem to bear out the opinions of those witnesses who said that a reporting officer was required for the hospital service. A large majority of patients were in favour of speaking either to a nurse or to a doctor. Moreover, the arguments raised against the appointment of a reporting officer appear to us to outweigh the arguments in favour, and we do not support such appointments. We return in Chapter 10 to the possible role of a commissioner as a final court of appeal.

105. What is required in the first instance is someone who is readily available to receive patients' comments so that action can be taken as quickly as possible; and we think that it is impracticable for hospital staff not directly connected with patient care to fill this role.

106. We accept that it is possible that someone closely connected with the welfare and treatment of the patient might take or might be thought to take a defensive attitude if a comment or particularly a complaint were made. An attempt can be made to overcome this attitude by allowing patients to insist on a comment being recorded and by making clear their right to communicate in writing with the hospital authority (para. 88). In addition our proposals regarding training (para. 119) may help counter the difficulty.

107. We therefore recommend that the sister should be the person to whom in-patients should speak in the first instance about any comments they may have, and that it should be the sister's duty to record these comments in the way suggested in Chapter 5. We make this recommendation because the sister is the person most closely and immediately connected both with the welfare of the patient and the administration of the ward. Thus, she is the person most

likely to be able to take immediate remedial action if this is possible, or the person most likely to know to whom the matter should be referred.

108. The same arguments apply to our recommendation that the sister in charge of the out-patient department should be the immediate recipient for comments from out-patients. We do not favour the suggestion that the receptionist should take on this duty because she does not have sufficient authority to take immediate remedial action. In the case of other para-medical departments providing out-patient services and where nursing staff might not be present (e.g. x-ray, physiotherapy, occupational therapy), we recommend that the recipient for oral comments should be one person in authority who has been clearly nominated to fill this role. In some cases the choice of person should be obvious (e.g. the superintendent physiotherapist in the case of a physiotherapy department), but we recognise the fact that the choice in some instances will depend on local circumstances. As regards venereal diseases clinics, we do not agree with the view that special "pastoral visitors" should be the immediate recipients for all comments; such a system would suffer from the same disadvantages as the reporting officer system considered in paragraph 98.

109. The same sort of argument seems, in our view, to rule out the use of an information centre as the first line for dealing with oral comments. Many hospitals do have an "enquiry point" at present, but information centres might have a more positive objective either combined with or separate from enquiry points. It is not for us to consider the need for such centres as places where information and guidance can be given to patients and visitors at large hospitals, but if they were established they could serve a valuable purpose as easily identifiable points for handing in written comments, though we could not recommend their establishment for this reason alone. These centres might also assist in improving communications generally between hospitals and the public, and prevent a number of complaints arising.

## CHAPTER 7

# The Investigation of Oral Comments

### Present Position

110. We are concerned in this chapter with the precise nature of the action to be taken when a comment is made orally to the sister.

111. The evidence we received tended to confirm the statement in the Farquharson-Lang report that if complaints, made orally to the nursing staff, "relate to matters other than nursing care or matters which cannot be settled by enlisting the aid of the medical staff who are responsible for the medical care of the patient, the ward sister will then report them to the matron. If they decide that *prima facie* the complaint requires investigation, it will be referred to the Medical/Physician Superintendent or Secretary and Treasurer, as appropriate". In short, the ward sister either deals with the matter or, if she cannot deal with it, reports it for investigation by some other person.

## Views Taken in Evidence

112. Certain principles in connection with the investigation of comments emerged from the evidence we received:

- (a) speed was essential;
- (b) investigation should be carried out by the person in authority most closely concerned with the patient;
- (c) where the comment related to the sister herself, the person in the next grade above the sister should carry out the investigation;
- (d) all comments should be treated confidentially;
- (e) no matter how trivial, all comments should be investigated thoroughly to prevent them growing into major issues;
- (f) there must be no tendency to ignore comments in an effort to prevent repercussions, and "whitewashing" must be strictly avoided;
- (g) all matters should be fully discussed with the patient, and if serious, written statements should be taken from both the patient and the staff concerned;
- (h) remedial action should be taken by the sister whenever possible;
- (i) in all cases, steps should be taken to ensure that the patient was told about what has been done and was satisfied.

113. A proposal was made that one step in the process of investigation should consist of the sister in all cases reporting "one-up" (i.e. to the person immediately senior) the fact that a comment had been made and the results of the investigation. This was seen as a method of ensuring prompt and correct action on the part of the sister. It was, however, pointed out by several witnesses that such a system would not necessarily ensure proper investigation, that it would detract from the rightful authority of the sister and might destroy the relationship between sisters and their patients when it was known that all comments had to be reported "one-up" as a matter of routine.

114. There was general agreement among witnesses that when a comment related to a matter other than those aspects of the care and welfare of the patient for which the sister was responsible, or when the matter was too serious to be handled by her, it should be referred to someone in higher authority for investigation. The choice of the person was divided fairly equally between the matron, medical superintendent and the hospital secretary. Clinicians giving evidence were asked whether as a matter of routine they should be informed about every comment by one of their patients even though not related to medical treatment. Some felt they would always want to know about comments from their patients, while others only wanted to know when the comment related to medical care.

115. One or two witnesses pointed out that the handling of patients' comments was an aspect of management which was dealt with only to a certain extent in the basic training of nursing staff, and that more could be done. Training of nursing staff in this aspect of management was vital, and management training courses should include this subject.

## Evidence from the Inquiry

116. When asked if they were satisfied with the way their complaint had been dealt with, only 28 per cent of patients who had complained said "yes"; forty-

three per cent were dissatisfied and seven per cent only partly satisfied. The main reasons for dissatisfaction were inadequate action (37 per cent) or patients feeling that nothing had been done (36 per cent). The pattern was similar in mental hospitals although relatives of patients in mental deficiency hospitals expressed more satisfaction than dissatisfaction, in contrast to patients themselves.

117. It is worth repeating that one of the reasons for the large majority of patients preferring to talk to staff about their comments was the opportunity to discuss matters. Patients generally felt that they would in this way "get an answer", "get the staff's opinion about the matter" and "be able to talk it over and sort the matter out".

## **Our Views**

118. We attach considerable significance to the number of patients who remained dissatisfied and the reasons given for this dissatisfaction. The inquiry demonstrates that it is important that patients should know the correct procedure for submitting comments, that these comments should be fully investigated, and that good communications are essential. To achieve this and to provide protection for staff, we regard it as essential that the various steps in the investigation of a comment should be detailed for each hospital and made known to the staff.

119. Training of hospital staff ought to cover this subject. All staff who have any contact with patients should be given training in the methods of establishing and maintaining good communications with patients. All staff who are liable to deal with comments should be trained specifically in the procedure we recommend. All management courses should contain this type of training as part of the syllabus; it is not enough that lectures should be given on the subject—practical training in the form of case-studies is also necessary.

120. We fully accept the principles outlined in paragraph 112. Comments should be investigated speedily, confidentially and thoroughly; there must be no tendency to turn a blind eye to them, and the results of the investigation should be discussed frankly with the complainant.

121. We do not agree with the proposal that a "one-up" procedure should be automatic. This would detract from the rightful authority of the sister and might destroy the relationship between sisters and their patients. The "comments book" will always be available for more senior staff to examine when they wish to do so.

122. The first step in the procedure immediately after a comment other than the most serious (para. 127) has been received, should be discussion with the patient. This should be conducted with as much privacy as circumstances permit. This procedure appears to be preferred by patients, and is essential in order to obtain the full facts and to assess any additional factors arising from the patient's physical or mental condition. We fully realise the burden of work which sisters have to carry, but it is a fundamental part of the duties of sisters to talk to their patients. We believe that a number of comments, which may have arisen through lack of information or misapprehension, will be fully resolved as a result of this initial discussion. Without it, such comments could well grow in the mind of the patient to disproportionate significance. We recognise that some consultants

would like to be told about every comment made by any of their patients, while others would be satisfied if the sister used her discretion in deciding whether to inform them of such comments. This seems to be primarily a matter for each consultant to decide for himself but we think that the decision should be at the discretion of the sister unless the individual consultant gives her guidance as to his wishes.

123. When a comment is not resolved as a result of this initial discussion, the sister should if necessary interview any member of staff under her control who may be able to provide further factual information. If, however, the comment relates to a member of the medical or other staff not under the control of the sister, she should, after clarifying the circumstances of the comment, inform the consultant in charge of the patient, or departmental head, immediately, should thereafter record the comment in the normal way, and inform the nominated recipient for written comments.

124. When the matter has been discussed and the facts obtained, the sister will be in a position to decide if remedial action is possible. If so, it should be taken and the patient should be immediately informed and given the opportunity for further discussion of the matter. If remedial action is not possible, the sister should inform the patient that this is the case, giving reasons and as much information as possible about what has been, or will be done to bring the matter to the attention of the responsible person. Again the patient should be given the opportunity for any further discussion of the matter.

125. At this stage in the procedure the sister should decide whether or not to record the patient's comments as discussed in Chapter 5. Where the comment is a serious one or where remedial action has not been possible, we recommend that the matter should automatically be recorded. Where remedial action has been possible, recording should depend on the significance of the comment and should be at the discretion of the sister (para. 87).

126. If remedial action is not possible or if the patient remains dissatisfied after action has been taken, the matter should be brought to the attention of the person responsible for dealing with written comments. The matter should by this time have been recorded in the "comments book" and we do not consider it necessary that the sister should make a written report at this stage; verbal communication with the person responsible should be sufficient.

127. On occasions it will be obvious to the sister during the course of discussion that a complaint is serious. We have in mind for instance a complaint regarding assault or ill-treatment by a member of staff. When the sister has established that the complaint is serious, her investigation should stop immediately, and the patient should be asked to put the matter in writing to the nominated recipient of written comments, and the sister should immediately inform him. If the patient is unable or unwilling to put the matter in writing, the sister should pass this information to the nominated recipient of written comments and inform the patient that this is being done. It will then be the responsibility of the nominated recipient of written comments to initiate further action in the way suggested in Chapter 8.

128. The various steps in the recommended procedure for investigating oral comments are shown in diagrammatic form in Appendix VI.

## The Investigation of Written Comments

### Present Situation

129. We are concerned in this chapter with the investigation of both written comments and written reports on comments initially received orally by ward sisters.

130. With regard to written comments, patients are given a variety of advice in existing information booklets about the person to whom written comments should be sent. These booklets normally designate either the matron, the medical superintendent, the hospital secretary or the group secretary as the recipient, and occasionally indicate two of these officers as alternatives. No examples of booklets were found which gave the name of the officer in addition to his or her title, and only in a few instances was an address given. It is not uncommon for booklets to state that written comments are welcomed without giving any indication of the correct recipient.

131. It is normal practice for comments made to the Secretary of State or Members of Parliament to be passed by the Scottish Home and Health Department for investigation to the appropriate regional hospital board, and in turn for regional hospital boards to pass comments to the appropriate board of management, although in some cases, with the agreement of the regional board, the comment is sent directly by the Department to the board of management concerned. When these investigations have been carried out, reports are sent to the original recipient to enable a reply to be made.

### Views Taken in Evidence

132. There was a wide consensus of opinion that the procedure for making written comments should be publicised in information booklets, and that the paragraph dealing with oral comments should also deal with written ones (Chapter 4). It was proposed, however, that although the submission of comments in writing should be given as an alternative to oral comments, it should be pointed out that the investigation of a written comment might take longer. It was also generally agreed that information booklets should state clearly the title and address of the recipient for written comments.

133. When considering who should be the recipient for written comments, opinion was evenly divided between the medical superintendent, the matron, and the hospital or group secretary. Many witnesses said that the identity of the recipient was less important than the need for both patients and staff to know who the correct recipient was.

134. In connection with the investigation of written comments, a number of witnesses were in favour of this being carried out either by a sub-committee of the board of management, or by an *ad hoc* committee of the board appointed for the purpose. In making this proposal, witnesses generally had in mind the investigation of serious comments, and suggested that these committees should be called at the discretion of the group secretary. The reason for investigation by a committee of the board was said to be the board's direct responsibility for the administration of the hospitals in the group. Another proposal put to us was

that functional committees should investigate comments which were relevant to them (e.g., the catering committee in the case of comments about food).

135. Other witnesses favoured either a committee consisting of a combination of members and officers, or a committee of senior officers alone, e.g., the medical superintendent, matron, group/hospital secretary and other relevant officers.

136. The majority of witnesses, however, favoured initial investigation by one senior officer, and generally by the particular officer who was the normal recipient for written comments. While some stated no preference, the choice of others was again fairly evenly divided between the senior officers.

137. With regard to psychiatric hospitals, the Mental Welfare Commission said that although their function was to investigate comments from psychiatric patients, they were aware that some comments were in fact investigated by the relevant hospital authorities. There was, however, in the view of the Commission, no great need for an alternative procedure in the case of written comments; it was essential that patients should always have the opportunity to take up comments either initially with the Commission, or to go to them if dissatisfied with the action taken by the hospital authorities.

138. It is inevitable that anonymous comments will be received from time to time. The majority of our witnesses considered that these should be ignored, but there was a fairly wide range of opinion, and several witnesses thought that anonymous comments could be useful.

## **Our Views**

139. We agree with the view of many witnesses that the vital need is that every patient should know who is the recipient for written comments in the particular hospital; if this is clear it does not much matter whether the person selected is the medical superintendent, the group secretary or the hospital secretary. The "nominated recipient" should be a specified senior officer in the hospital or group and he should be readily available to deal with serious matters as they arise, with a substitute appointed during his absence. Because of the widely differing organisation of hospitals and groups, we think it must be left to local discretion to decide which senior officer should be selected and whether there should be one or more recipients in the group. There are, for example, hospital groups so large that the group secretary could not be expected to undertake this task for all hospitals in the group, and there are groups with no medical superintendents. Where circumstances permit we think that there should be only one nominated recipient in the group since this arrangement should cause less confusion among staff and patients, should allow the recipient to acquire great skill in handling comments and should enable him to build up a good relationship with other people in the same field (e.g. the Legal Adviser).

140. We recommend that each board of management should examine the circumstances within the group and should determine first, whether one senior officer in the group should be nominated to undertake this duty. If more than one officer is needed for the group, the board should nominate a senior officer for one or more hospitals. Thereafter, the information booklet in use in the hospital or group should state clearly the title and full address of the nominated recipient.

141. As in the case of oral comments, we think it necessary for each board of management to detail the various steps in the investigation of a written comment and to make these steps known to the nominated recipient and to staff in general. The presentation of this procedure would need to take account of guidance issued by the Scottish Home and Health Department to hospital authorities for other categories of cases; for example, advice has been given about procedure where criminal offences are suspected (S.H.M. 75/1968), procedure where disciplinary action may be required (RHB(S) (53)3) and disciplinary procedure in cases involving the professional conduct or professional competence of hospital medical and dental staff (S.H.M. 49/1968). Boards of management should ensure that the procedure they lay down for the investigation of written comments is not at variance with such advice.

142. In general terms we recommend that the steps in the investigation of written comments, after they have reached the nominated recipient should be as follows:

(a) the nominated recipient should first consider whether the comment might involve civil litigation, criminal or disciplinary proceedings. If so, the matter should be dealt with as recommended by the Department. Where the comment might lead to litigation, the Legal Adviser should be consulted at the earliest possible moment. <sup>(1)</sup> Where a comment relates to an accident, the normal procedure in cases of accidents should be carried out simultaneously;

(b) unless the circumstances make it necessary for the facts to be investigated by someone outside the hospital (e.g. the police), the nominated recipient should obtain the facts himself or should arrange for an appropriate senior officer to do so. Where, for example, the group secretary is the nominated recipient, it may be necessary for him to ask the medical superintendent to obtain the facts about a comment concerning a medical matter or the matron to investigate a comment concerning a nursing matter. It should always, however, remain the responsibility of the nominated recipient to ensure that the case is investigated, that he is informed of the result of the investigation and that all subsequent action is taken. To obtain the facts it may be necessary for the nominated recipient or other senior officer to interview a number of people. In many cases it may be sufficient to discuss the matter with the sister, who may already have carried out her own investigation; but the officer concerned should not be reluctant to interview any person for a second time if there is any possibility of this being helpful;

(c) when all the facts have been obtained, the recipient for written comments should take remedial action when it is in his power to do so or arrange for another senior officer to take such action. If remedial action is not possible, it may be necessary to prepare a report for the immediate attention of the board of management;

(d) in all cases coming to the nominated recipient from hospital sources, the nominated recipient should write to the patient concerned and tell him what has been done; and in some cases it may be advisable to supplement the letter by a talk with the patient. If the patient remains dissatisfied the matter should always be reported to the board. In cases coming from other

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(1) See S.H.M. 55/42 and C.L.O. 1.

sources (e.g. the regional board), the nominated recipient should as soon as possible report back in writing the results of the investigation;

(e) the nominated recipient should keep a record of all written comments and the action taken, irrespective of the source.

The various steps in the investigation of written comments are shown in diagrammatic form in Appendix VII.

143. We consider that this procedure would be suitable for all types of hospitals, including mental and mental deficiency hospitals where it should not interfere with the work of the Mental Welfare Commission. Patients would, of course, retain the right to make a direct approach to the Commission, and the nominated recipient might himself want to refer individual cases to the Commission. Members of the Commission should also have the right to inspect "comments books" retained in the wards and the records maintained by the nominated recipient.

144. We recommend that information booklets should stress the need for all written comments to be signed. It must, however, be expected that anonymous comments will sometimes be received either by the nominated recipient or other officers; and it may not always be right to ignore them. We do not think, however, that anonymous comments should be dealt with formally by the procedure outlined above; they should not form a direct basis for action under this procedure, they should not be used against any individual member of staff and they should not be included in the records of the nominated recipient or in any report submitted to the board of management.

## CHAPTER 9

### Involvement of Boards and Other Authorities

#### INVESTIGATION BY HIGHER AUTHORITIES

145. The Ministry of Health Memorandum concerning the methods of dealing with complaints (Appendix II) recommends that any complaints which could not be dealt with satisfactorily by officers should be reported to the board of governors or hospital management committee or to an appropriate committee for decision as to further action, and where further investigation was considered necessary, they could decide either to have an investigation carried out on their own behalf or refer the matter to an independent authority for investigation.

#### Views Taken in Evidence

146. From the information received in evidence, it seemed that situations could arise when senior officers at board of management level would be unable to deal completely with comments for one or more of the following reasons:

- (a) the comment concerned the policy of a higher authority;
- (b) the comment concerned an employee of a regional hospital board;

- (c) the comment involved, or might involve, criminal or disciplinary proceedings or litigation;
- (d) the complainer remained dissatisfied after investigation and remedial action by the responsible officer;
- (e) in general, the comment was too serious to be dealt with by an officer of the board.

147. Despite the fact that a small number of witnesses recommended that all written comments should be dealt with by some type of committee (para. 134), the majority of witnesses were of the opinion that the board (or one of its committees) need deal with only the most serious cases, cases concerning general policy matters, or those about which the complainer remained dissatisfied. The complainer would, however, always retain the right to communicate direct with the board.

148. It was pointed out that, where a comment was likely to involve litigation, there were recognised arrangements for the handling of such matters.<sup>(1)</sup> In the case of comments which concerned an employee or policy of a regional hospital board, witnesses agreed that the matter should be referred to that board. One regional board stressed the point that consultation with the regional board should be an integral part of the procedure for dealing with comments.

## Our Views

149. While adhering to the general principle that comments should as far as possible be dealt with by officers, we agree that comments about matters of policy should be referred to whichever authority is responsible for formulating the policy. This is not to say, however, that investigation of comments regarding policy matters should not be undertaken by the nominated recipient. We recommend that when investigation has been carried out, a report of the circumstances and a recommendation of what changes in policy might be considered should be submitted by the nominated recipient to the board of management, or to the regional board through the board of management. In such cases, remedial action as far as the patient is concerned may be impossible, but he should be fully informed of what is being done.

150. We also recognise the fact that comments may arise about an employee of a regional hospital board. Comments in such instances are likely to concern medical staff, since other employees of regional boards are less likely to be in contact with patients. We do not think that a comment about an employee of a regional board working in a hospital need be investigated by another employee of the regional board staff, though the regional board should be informed of the position and their views sought about the correct method of investigation.

151. In the general run of cases, however, when the complainer remains dissatisfied after investigation of a written comment and remedial action by the officer, we recommend that the matter should be referred to the board of management for consideration of further action. There appear to us to be four courses of action open to the board:

- (a) it can agree that action taken by the nominated recipient was correct and sufficient to remedy the matter. This decision with a reasoned explanation

(1) These arrangements are outlined in S.H.M. 55/42 and Circular C.L.O. 1.

tion should be made known to the complainer, who should normally be told what further action to take if still dissatisfied;

(b) it can ask for further investigation to be undertaken, or can make arrangements for further investigation to be carried out;

(c) it can agree to take further remedial action which was outwith the authority of the nominated recipient;

(d) it can agree to refer the matter to a higher authority.

152. In amplification of (b) above, the board of management may want to arrange for a further informal investigation by some of its own members through, for example, a meeting between these members and the complainer, in order that the position can be discussed. The more that can be done informally the better, provided always that the board of management is particularly careful to ensure that any informal action could not be held to prejudice their impartiality if more formal proceedings become necessary. Alternatively, or in addition, the board may want to appoint one or more of its members to undertake a more formal investigation and report the results to the board. Where such an investigation is ordered by the board, the complainer should always have the right to be accompanied by a friend in any meeting with the board members, as should any member of the staff or other person affected by the complaint. It is not envisaged that legal representation would be needed at such an investigation.

153. In amplification of (d), cases which the board of management regard as too serious for them to deal with, cases in which members of the board of management have been involved at an earlier stage, or serious cases affecting employees of the regional board should be reported to the regional board which would have the choice of carrying out any further investigation itself, appointing an independent inquiry to undertake an investigation, or asking the Secretary of State to order an inquiry in terms of section 69 and the Tenth Schedule of the National Health Service (Scotland) Act, 1947.

154. If the regional board decides to investigate the matter itself it should act in the same way as suggested for the board of management in paragraph 152. If, however, the board wishes to set up an independent inquiry it would first seem desirable for it to consult the Scottish Home and Health Department in order to ensure consistency of approach towards such inquiries throughout Scotland. Generally, we agree with the recommendations in the Ministry of Health Hospital Memorandum (Appendix II) that such an inquiry should be held by an independent lawyer or other competent person from outside the hospital service acting either on his own or as chairman of a small committee whose members should be drawn from a different region and should include a person, or persons, with particular knowledge of any professional or technical matters involved. We agree too that the complainer and any person affected by their complaint should have an opportunity to be present throughout the hearing, to cross-examine witnesses and to be allowed to make their own arrangements to be legally represented if they so wish.

155. If the Secretary of State decides to set up an inquiry in terms of section 69 of the 1947 Act, the procedure would be in accordance with the Tenth Schedule of that Act and would come under the supervision of the Council on Tribunals and its Scottish Committee. It seems advisable that the procedure adopted by any independent inquiry set up by a regional board should be acceptable to the

Council and, while there is no statutory requirement for the Council to be concerned with such inquiries, we consider that the Council's Scottish Committee should be consulted informally. This is an additional reason for bringing in the Scottish Home and Health Department in all cases where an independent inquiry is envisaged.

156. In cases affecting mental, or mental deficiency hospitals the board of management should refer complaints which it regards as serious to the Mental Welfare Commission and invite the Commission to undertake such inquiry as they think necessary.

### **Reporting to Higher Authorities about Numbers of Comments**

157. The Ministry of Health Memorandum (Appendix II) suggested that "it may be useful to Boards and Committees in assessing the service being provided to the public to receive periodic reports of the number and types of written complaints, graded according to importance and subject, and they are asked to consider the desirability of introducing such a procedure where it does not already exist". The Ministry of Health followed up this circular in December, 1966 by requesting secretaries of boards of governors and regional hospital boards in England and Wales to submit reports of the number and types of written comments, and instructing them to keep records of written comments from 1st January, 1967 onwards showing the numbers of comments under the headings of those dealt with by officers, by a committee of the board, or by an independent enquiry and to distinguish, in each of these categories, between those concerned wholly or partly with clinical matters and those which are not.

### **Views Taken in Evidence**

158. Witnesses from regional hospital boards were of the opinion that reports of complaints received by boards of management should be periodically submitted to them as part of the general control carried out by them. These reports should detail the type of complaints received, the action taken to remedy them, and the lessons to be drawn from these complaints. These views were supported by a number of boards of management.

### **Our Views**

159. We endorse the recommendation of the Farquharson-Lang report that boards of management should receive regular reports of comments, classified according to their nature and importance (i.e. the level at which they are handled), and indicating the action taken. Reports in turn should be submitted to regional boards showing the numbers of comments under the headings of those dealt with by the first recipient, by the nominated recipient for written comments, referred to the board of management or to a higher authority. The aim should always be to ensure that complaints from individual patients are dealt with effectively and to find out where the service is not meeting the needs of patients collectively, so that remedial action can be taken. We have made allowance for the reporting of oral comments by the periodic submission by sisters of the "comments book" to the nominated recipient. As already mentioned, we do not think that anonymous comments should be included in these reports (para. 144).

## The Role of a Health Commissioner

160. There has been growing demand for the provision of a final court of appeal in cases of complaints by members of the general public against government departments or against public services administered or controlled by government departments. This culminated in 1966 with the appointment of the Parliamentary Commissioner for Administration, although he has no jurisdiction over the hospital service. Since then the need for the jurisdiction of the Parliamentary Commissioner to be extended to cover the hospital service or some other form of appellate machinery introduced into the service has been advocated widely.

### Evidence Received

161. We have received some evidence from witnesses about a final court of appeal, including the role of the Parliamentary Commissioner in the hospital service, the role of special tribunals and the possibility of a hospital commissioner or inspectorate; and we were specially requested by one board of management to give the matter consideration. The word "ombudsman" was used by a number of witnesses, and as mentioned in paragraph 97 there appears to be a certain amount of confusion between the concept of the hospital "ombudsman" as a "reporting officer" and as a "commissioner". It was suggested that the function of the "ombudsman" as a "commissioner" would be to "maintain a watching brief over our hospitals generally". As in the case of the "ombudsman" as "reporting officer", the virtues of such an appointment were said to be the detachment and impartiality of the person holding the post.

162. In December 1968 the Secretary of State published a Green Paper entitled "Administrative Reorganisation of the Scottish Health Services."<sup>(1)</sup> The paper puts forward tentative proposals for a new administrative structure for the National Health Service in Scotland, including proposals about a final court of appeal in the case of serious complaints. The Minister of Health published a similar Green Paper in July 1968 entitled "The Administrative Structure of the Medical and Related Services in England and Wales."<sup>(2)</sup>

163. It was brought to our attention that following allegations of ill-treatment of patients at Randolph Wemyss Hospital an independent committee of enquiry, headed by an advocate, was set up by the South-Eastern Regional Hospital Board, Scotland, and that there have been several committees of enquiry set up in England and Wales following publication of "Sans Everything".

164. At a recent meeting of the National Association for Mental Health it was argued that a body, such as the Mental Welfare Commission, with other than mental hospitals under its jurisdiction, could have dealt very much more quickly with the recent allegations of ill-treatment at the Randolph Wemyss Hospital. A case was made for introducing for all hospitals such a body as the final court of appeal, using the Mental Welfare Commission as a model.

(1) and (2) H.M.S.O. 1968.

## **Our Views**

165. We have not taken evidence on the subject of a final court of appeal consistently from all witnesses since we felt that detailed consideration of the procedure for handling complaints which required investigation by a body outside the hospital service was not strictly within our terms of reference which relate to procedure within the hospital service. If we were to consider this subject in detail, we should need to delay our report in order to obtain evidence from a wider range of interests, and more consistently from our previous witnesses; this, we think would be an unjustifiable extension of our work.

166. Moreover, the Health Ministers have initiated wide discussion on the future structure of the service, including the question of a health commissioner, and this makes it clear that the subject is to be considered by the Government in this context. We doubt whether detailed consideration by us of the position, even if such consideration were within our terms of reference, could add much to the wider consideration which is due to be undertaken. It would seem sufficient, therefore, if we commented on the general principle of some form of machinery for investigating complaints in the light of the evidence we have received and of our recommendations about the procedure to be adopted within the service.

167. One of the functions of members of hospital authorities is to promote the interest of the general public and the patients and we are sure that members are conscious of this responsibility and do their best to carry it out. Nevertheless, members are closely connected with the administration of the hospitals in their charge and are not always regarded by patients and by the public as independent of those hospitals. We do not think that there will be many complaints arising in the hospital service that could not be handled by the internal procedure which we recommend, but it would be rash to assume that no such cases will occur.

168. We regard it as most important, therefore, that some recognised machinery should be devised to handle complaints of a kind which cannot properly be handled within the service and we hope that some such machinery, which should not be too closely associated with the hospital and the interests of hospital staff but at the same time not too remote to lack sufficient understanding of the position, will be introduced as part of the review of the administrative structure of the health service.

## **CHAPTER 11**

### **Summary of Conclusions and Recommendations**

#### **Introduction (Chapter 1)**

169. It is very important to ensure that any steps taken to protect the interests of patients do not place an unreasonable burden on hospital staff or harm their interests (para. 4).

## **Terminology and Classification (Chapter 2)**

170. Use of word "complaint" cannot be avoided but it should not be unduly emphasised. It will not be unduly emphasised if used in a phrase such as "suggestions and complaints" (para. 31).

171. Classification of the subject matter of comments is difficult because of the amount of overlap between the various headings. Formal classification is not necessary, but may be useful for record purposes. It is undesirable to divide comments according to the degree of seriousness because the importance attached to a comment is largely a matter of subjective judgment (paras. 32-34).

## **The Necessity for Having a Procedure Known to Patients (Chapter 3)**

172. The present arrangements for dealing with comments are not adequate. To allow a consistency of approach, there should be one procedure which is appropriate in all types of hospitals. The procedure should be in two parts: the first simple and informal for dealing with comments at ward level, the second precise and formal for comments which cannot be dealt with in this way (paras. 48-49).

## **Publicising the Procedure (Chapter 4)**

173. It is essential that the procedure should be publicised (para. 53).

174. Information booklets with an appropriate paragraph are ideally suited for publicising the procedure at the most appropriate time for the greatest proportion of in-patients and without giving the matter undue emphasis (paras. 67-68).

175. The policy of providing information booklets with an appropriate paragraph should be extended as quickly as possible to all hospitals in the country (para. 66).

176. Information booklets should be sent to patients before admission. Booklets should also be available in wards and dayrooms (para. 67).

177. Hospitals which do not yet produce an information booklet containing an appropriate paragraph should in the meantime provide information about the procedure on the back of the patients' admission card or similar document, or, if necessary produce a document dealing specifically with the subject (para. 71).

178. For out-patients, the information should be given on the back of the patients' appointment card, and attention should be drawn to the matter by a notice in each out-patient department (para. 72).

179. For patients admitted in emergency, there should be a routine procedure for providing information booklets as soon as possible after admission (para. 73).

## **The Recording of Comments at Ward Level (Chapter 5)**

180. Patients should be encouraged to make oral rather than written comments. Oral comments should normally be recorded at ward or departmental level. On occasions, because of the nature of the comment, the patient should be requested to put the matter in writing (para. 86).

181. It would be an unreasonable burden on hospital staff to ask them to record every comment, no matter how trivial. Discretion should therefore be used in recording comments, but where there is doubt, a record should be made. Every patient should have the right either to insist on a comment being recorded, or to communicate in writing with the hospital authority (paras. 87-88).

182. The recording should be done in a "comments book" kept in each ward or department for that purpose. The record should not be over elaborate. This system should apply in all types of hospitals (paras. 89-92).

### **The First Recipient of Oral Comments (Chapter 6)**

183. Special reporting officers are not necessary for the hospital service (paras. 104-105).

184. The sister should be the person to whom in-patients should speak in the first instance about comments and it should be her duty to record these matters (para. 107). In out-patient departments the sister, or where there is none, the person in authority and clearly nominated for the purpose, should be the immediate recipient for comments (para. 108).

185. It is possible that staff might take or might be thought to take a defensive attitude to comments. Attempts to overcome this can be made by allowing patients to insist on a comment being recorded and by staff training (para. 106).

186. The need for an Information Centre in large hospitals should be considered (para. 109).

### **The Investigation of Oral Comments (Chapter 7)**

187. Each board of management should detail the various steps in the investigation of a comment for each of their hospitals and make them known to the staff (para. 118).

188. All staff who have any contact with patients should be trained in methods of establishing and maintaining good communications with patients. Staff who are liable to deal with comments should be trained in the procedure. All management courses should provide practical and theoretical training in dealing with comments (para. 119).

189. The investigation of comments should be carried out quickly, confidentially, thoroughly and wherever possible by the person who receives the comment. No comment should ever be ignored, and the results of the investigation should be discussed with the complainer (para. 120).

190. The first step in the investigation of oral comments should be discussion with the patient in order to obtain the facts. The decision whether the consultant in charge of the patient should be informed of every comment should be at the discretion of the sister unless individual consultants give her guidance as to their wishes (para. 122).

191. If a comment is not resolved after the initial discussion, the sister should interview any member of staff under her control who may be able to provide further factual information. Where a comment relates to a member of the medical staff, or staff not under her control, she should inform the consultant in charge of the patient, or departmental head, and record the comment in the recommended way (para. 123).

192. Where possible, the sister should take remedial action and inform the patient immediately, and have further discussion with the patient if necessary. At this stage the sister should decide whether or not to record the comment (paras. 124–125).

193. If remedial action is not possible or the patient remains dissatisfied, the matter should be brought to the attention of the nominated recipient of written comments (para. 126).

194. When it is established that a comment is serious, the investigation should stop immediately and the patient should be asked to put the matter in writing, or it should be reported immediately to the nominated recipient of written comments (para. 127).

195. The recommended procedure for dealing with oral comments is shown diagrammatically in Appendix VI.

### **The Investigation of Written Comments (Chapter 8)**

196. The vital need is for every patient to know who the recipient for written comments is in the particular hospital. If this is clear, it does not much matter which of the senior officers is selected. The nominated recipient of written comments should, if possible, be one specified senior officer in the hospital or group. Each board of management should examine the circumstances within the group and determine whether one or more senior officers should be nominated (paras. 139–140).

197. Each board of management should detail the various steps in the investigation of a written comment, and make these steps known to the nominated recipient and staff in general. In doing this, account will require to be taken of the guidance issued on the procedure where legal action may be taken or disciplinary action may be required (para. 141).

198. The nominated recipient should take the following steps in investigating a comment:

- (a) ascertain whether the comment might involve civil litigation, criminal or disciplinary proceedings; if so, the matter should be dealt with as recommended by the Scottish Home and Health Department and the Legal Adviser;
- (b) unless circumstances require otherwise, obtain the facts or arrange for an appropriate senior officer to do so. He should always be responsible for ensuring that a case is investigated, that he is informed of the result and that all subsequent action is taken;
- (c) take remedial action himself or arrange for another senior officer to do so;
- (d) in cases coming from hospital sources, write to the patient concerned telling him what has been done, and also, where necessary, discuss the matter;
- (e) in cases coming from other sources, report back in writing as soon as possible;
- (f) keep a record of all written comments and the action taken (para. 142).

199. The recommended procedure for dealing with written comments is shown diagrammatically in Appendix VII.

200. This procedure should be suitable for all types of hospitals, but in the case of mental and mental deficiency hospitals, the nominated recipient might also wish to refer cases to the Mental Welfare Commission, and the patients in such hospitals should retain the right to make a direct approach to the Mental Welfare Commission. Members of the Commission should be free to inspect "comments books" retained in the wards, and the records maintained by the nominated recipient (para. 143).

201. Information booklets should stress the need for all written comments to be signed. Anonymous comments should not be dealt with formally, nor form a direct basis for action under this procedure, nor be used against any individual member of staff, or be included in any records (para. 144).

### **Involvement of Boards and Other Authorities (Chapter 9)**

202. Comments about matters of policy should be referred to whichever authority is responsible for formulating the policy, although the investigation should be carried out by the nominated recipient (para. 149).

203. Written comments involving regional board employees working in hospitals should normally be referred to the nominated recipient in the hospital, and remedial action should be taken as agreed with the regional board concerned (para. 150).

204. Where remedial action is not possible, the matter should be referred to the appropriate employing authority with a report of the investigation (para. 151).

205. Boards of management may want to undertake further informal inquiries through their members, but care must be taken to avoid prejudicing the boards' position in relation to any formal proceedings that might follow (para. 152).

206. Where the board of management want themselves to undertake formal investigation, the complainant and any person affected by their complaint should have a right to be present throughout the proceedings and to be accompanied by a friend (para. 152).

207. More serious cases should be passed to the regional board who may want to set up an independent inquiry to consider them. An outline procedure is suggested for such inquiries. The Scottish Committee of the Council on Tribunals should be consulted about procedure (paras. 153-154).

208. Serious cases in mental and mental deficiency hospitals should be reported to the Mental Welfare Commission (para. 156).

209. Both categories of boards should obtain regular reports about the numbers of oral and written comments, classified according to their nature and importance and indicating the action taken (para. 159).

### **The Role of a Health Commissioner (Chapter 10)**

210. Consideration of the need for a final court of appeal is being undertaken by the Government and it would be inappropriate for us to consider the position

in detail, though we consider that a recognised machinery should be introduced to handle complaints of a kind that cannot properly be handled through the Service (paras. 165-168).

E. U. E. ELLIOTT-BINNS, *Chairman*

W. K. BOWIE

ALEC H. DUNCAN

J. HARLAND

JANET T. LOCKE

JAMES MILNE

R. J. NORMAND

JOHN J. ROSS

W. R. MILLER, *Assessor*

G. A. SCOTT, *Assessor*

IAN G. DORWARD, *Secretary*

February, 1969.

## APPENDIX I

### Extract from Report of Farquharson-Lang Committee

"While the handling of complaints and suggestions from patients could be regarded as essentially a matter for the internal administration and thus for officers, we have already pointed out that the board has a responsibility for the oversight of the patient's care and as a 'consumer' council. We have, therefore, reviewed the existing arrangements, primarily in relation to the functions of the board.

Complaints are most frequently made orally to the nursing staff, and, if they relate to matters other than nursing care or matters which cannot be settled by enlisting the aid of the medical staff who are responsible for the medical care of the patient, the ward sister will report them to the matron. If they decide that *prima facie* the complaint requires investigation, it will be referred to the Medical/Physician Superintendent or Secretary and Treasurer, as appropriate. Should the complaint be so serious that it may give rise to legal action, a written statement may have to be obtained from the patient, or his legal representative, and thereafter the matter may have to be dealt with formally in correspondence between the service and the legal representative. Complaints can, therefore, range in gravity from those which might give rise to legal action, through the category which can be remedied by internal administration, to the trivial and frivolous. There is, however, ordinarily no recognised channel, known to patients or relatives, for the making of a complaint, or for further representations, if they are dissatisfied with the steps taken to investigate it. Indeed, it is doubtful whether the average patient is aware that there is a governing body controlling and managing the services provided for him. Nor are there any similar, recognised, arrangements for receiving suggestions from patients, who may be reluctant to trouble medical and nursing staff already fully preoccupied with their immediate tasks.

Since this is a public service, we think that there must be a channel known to patients and relatives, as well as to the internal administration, through which the public can make suggestions or complaints. We are not suggesting that patients are in general dissatisfied. Indeed, it has been pointed out to us that, in relation to the half-million in-patients discharged and the two million new out-patients accepted each year in Scottish hospitals, the number of complaints that reach senior officers or board members is negligible. On the other hand, it can be argued that, as boards do not normally keep records of complaints and as most patients do not know how to proceed (their circumstances are in any event likely to discourage initiative), the extent of any dissatisfaction may be greater than the service realises. The growth of patient 'pressure' groups and the complaints addressed to the Secretary of State, which can run to two or three hundred per annum, lend some support to the belief that there is room for improvement in the services rendered both generally and to the individual patient. We should emphasise, however, that we are not so much concerned here with the exercise of clinical skills for the treatments of the specific disease or disability, but rather the comprehensive standard of care for the individual, with a view to restoring him his life within the community as soon as practicable.

We recommend that:

- (a) All boards should be required to institute a recognised procedure, known to patients and relatives, for the handling of complaints and suggestions. This procedure should cover both the internal administrative arrangements and those for representation or complaint to the board, where patients or relatives are dissatisfied with the steps taken by the internal administration. The procedure will have to take account of the possible legal implications arising from certain serious complaints.
- (b) A Working Party should be appointed by the Secretary of State to devise such a procedure. So far as the practice of boards is concerned, speed in response to representations is of paramount importance.
- (c) Boards should obtain regular reports on complaints, classified according to their nature and importance and indicating the action taken, with two aims in

mind. The first is to ensure that complaints from individual patients are being dealt with effectively; the second is to ascertain in what respects the services provided are not meeting the needs of patients collectively, so that remedial action can be taken. (Most large undertakings providing services take pains to assess consumer reaction, and we can see no reason why the hospital service should not make use of this widely accepted management practice). We are not, of course, suggesting that the patient is in a position to judge the success of the clinical skills which have been applied to him; but even in relation to the other aspects of patient care there is a very large field in which the service will find itself being judged by the public.

Lastly, boards and officers should avoid the natural tendency to react defensively against any public criticism. In any service provided to the public complaints are inevitable, but they should be regarded as an aid to efficient management. Similarly with regard to suggestions, the service has a comprehensive cross-section of the community as patients, some of whom should be able, from intelligent observation during the recuperative stages, to comment upon the running of the hospital as only the patient can see it. Full advantage should be taken of constructive comments from them."

(Paras. 143-147)

## APPENDIX II

### "Methods of Dealing with Complaints by Patients"

(Ministry of Health Memorandum H.M.(66)15)

**Summary** This memorandum sets out the procedure for enquiring into complaints made by, or on behalf of, patients.

1. The Minister appreciates the care given by hospital authorities to the consideration of complaints made by, or on behalf of, patients. Information provided by Hospital Boards shows that in general authorities realise the importance of ensuring that all such complaints are sympathetically received and fairly and speedily dealt with. There is virtue, however, in adherence to a well recognised procedure; and the Minister thinks it appropriate that there should be general guidance about what this should be.

2. Two general principles apply to all that follows. First, all complaints should be dealt with as promptly as the circumstances require. Secondly, not only should complaints be investigated, but it should be made evident to complainants that their complaints have been fully and fairly considered.

3. Complaints vary from those arising merely from misunderstanding or ignorance of hospital procedures, which often need only a word of explanation from an appropriate member of the staff, to those calling for formal enquiry by or on behalf of the hospital authority. The procedure outlined in paragraph 7 is therefore designed to cover complaints ranging from the relatively minor to the most serious, and the Minister hopes that this procedure will be adopted for all complaints which cannot be dealt with on the spot, subject to possible variations in different types of hospital (for example, special arrangements may often be needed in psychiatric hospitals), and to what is said in paragraph 4.

4. The guidance in R.H.B.(51)80 and H.M.(61)112 should continue to be applied in the serious disciplinary cases with which those memoranda deal. Also the guidance in H.M.(55)66 should continue to be applied when there is an accident in hospital; statements and reports should be obtained in the manner outlined in that memorandum, and they will be legally privileged documents.

5. Where Court proceedings in relation to the subject matter of a complaint have been started or are thought likely, hospital authorities should consult their legal

advisers before dealing or continuing to deal with the complaint. Whenever investigation of a complaint may point to action to ensure the proper running of the hospital, however, the authority will wish to take such action without delay, and legal proceedings or the likelihood of legal proceedings should not deter the authority from themselves carrying out whatever investigation is needed to this end.

6. Hospital Management Committees should consult the Regional Hospital Board at an early stage in all cases which appear serious or involve wider issues than the day-to-day administration of the hospital.

7. Subject to these general observations, the following procedure should apply:

- (i) Complaints made orally which cannot be dealt with forthwith to the complainant's satisfaction should be reported for consideration to a senior member of the staff in the department to which they relate, who should make a brief note of the complaint and of the circumstances. Appropriate action should be taken, and the complainant informed of the result. Where the complainant is not satisfied, he should be told that he can take his complaint to a higher level, and if he decides to do so he should be asked to put it in writing or, if necessary and if he agrees, it can be put in writing at his dictation by a member of the staff and signed by him. The complainant should be told to whom the complaint should be addressed.
- (ii) Any written complaint should be seen by the Secretary of the Board of Governors or Hospital Management Committee or by a senior member of his staff designated by him, and the action taken or to be taken on the complaint should be agreed by him after consultation with the Head of the Department(s) concerned.
- (iii) Any complaints which cannot be satisfactorily dealt with by officers in this way should be reported to the Board of Governors or Hospital Management Committee or to an appropriate committee for decision as to further action. Where the Board or Committee consider that further investigation is necessary, they may decide:
  - (a) to appoint one or more members of the authority to make an investigation and report back; (Alternatively, a Hospital Management Committee may ask the Regional Hospital Board—or the Board may decide, following a reference under paragraph 6—to appoint one or more of its members to make such an investigation) in such a case, where it might assist the investigation, or where he so desires, the complainant, accompanied by a friend if he wishes, should be present and allowed to be heard; as also should the person complained against, if he wishes;
  - (b) in the small number of cases which are so serious that they cannot be dealt with satisfactorily in this way, that the investigation should be referred for independent enquiry. Action to refer such cases should be taken by the Board of Governors or the Regional Hospital Board concerned on a reference from the Hospital Management Committee. The general rule should be that an independent lawyer or other competent person from outside the hospital service should conduct the enquiry, or preside over a small committee set up for the purpose, whose membership should be independent of the authority concerned and should include a person or persons competent to advise on any professional or technical matters. The complainant and any persons who are the subject of the complaint should have an opportunity of being present throughout the hearing, and of cross-examining witnesses, and should be allowed to make their own arrangements to be legally represented if they so wish.

8. In all cases replies to complaints, including replies given after enquiries have been held, should be given with sufficient explanation and in appropriately sympathetic terms.

9. Where a complaint is received by the Minister and sent to the Board for observations (or where a complaint is received direct by a Regional Hospital Board), the procedure recommended in paragraph 7(ii) or (iii)(a) above should be followed if the complaint has not been previously investigated, but action under paragraph 7(iii)(b) should not be taken without reference to the Minister when the complaint has been referred by him.

10. It may often be useful to Boards and Committees in assessing the service being provided to the public to receive periodic reports of the number and type of written complaints, graded according to importance and subject, and they are asked to consider the desirability of introducing such a procedure where it does not already exist.

Ministry of Health,  
Alexander Fleming House,  
Elephant and Castle,  
London, S.E.1.

7th March, 1966.

### APPENDIX III

#### Persons and Organisations Giving Evidence

The following persons and organisations gave evidence to the working party. The asterisk against some entries indicates that in addition to written evidence, oral evidence was also submitted. A dagger indicates that oral evidence only was submitted.

#### HOSPITAL BOARDS

##### Regional Boards

- \*Eastern
- \*Northern
- North-Eastern
- \*South-Eastern
- \*Western

Murray Royal and Murthly Hospitals  
County and City of Perth General  
Hospitals  
County of Angus General Hospitals

##### Boards of Management

###### NORTHERN REGION

Inverness Hospitals  
Ross (Mainland) Hospitals  
Lews and Harris Hospitals  
Sutherland Hospitals  
Caithness Hospitals  
Nairn Hospitals

###### SOUTH-EASTERN REGION

Royal Infirmary of Edinburgh and  
Associated Hospitals  
\*Edinburgh Northern Hospitals  
Edinburgh Central Hospitals  
Edinburgh Southern Hospitals  
Edinburgh Royal Victoria and Associated  
Hospitals  
Astley-Ainslie, Edenhall and Associated  
Hospitals  
Royal Edinburgh Hospitals  
\*East Fife Hospitals  
\*Stratheden and Associated Hospitals  
West Lothian (Bangour) Hospitals  
Gogarburn Hospital  
\*East Lothian Hospitals  
\*Borders Hospitals  
Dingleton Hospital

###### NORTH-EASTERN REGION

\*Aberdeen General Hospitals  
Aberdeen Special Hospitals  
Royal Cornhill and Associated Hospitals  
Buchan Hospitals  
Kincardine Hospitals  
Banffshire Hospitals  
Moray Hospitals  
Orkney Hospitals  
Shetland Hospitals

###### WESTERN REGION

Glasgow Western Hospitals  
\*Glasgow Royal Infirmary and Associated  
Hospitals  
Glasgow Maternity and Women's Hospi-  
tals  
Glasgow Northern Hospitals

###### EASTERN REGION

Dundee Northern Hospitals  
Dundee General Hospitals  
Dundee Dental Hospital

Glasgow Victoria Hospitals  
 Glasgow South-Western Hospitals  
 Gartnavel Royal Hospital  
 Glasgow North-Eastern Hospitals  
 Leverdale Hospital  
 \*Lennox Castle and Associated Hospitals  
 Campbeltown and District Hospitals  
 Dunoon Hospitals  
 Oban and District Hospitals  
 Lochgilphead Hospitals  
 Isle of Arran Hospitals  
 Bute and Cumbræ Hospitals  
 Northern Ayrshire Hospitals  
 \*Southern Ayrshire Hospitals

Dumfries and Galloway Hospitals  
 Crichton Royal Hospital  
 Dunbartonshire Hospitals  
 Coatbridge, Airdrie and District Hospitals  
 Motherwell, Hamilton and District  
 Hospitals  
 Southern Lanarkshire Hospitals  
 Central Lanarkshire Hospitals  
 Paisley and District Hospitals  
 Greenock and District Hospitals  
 Dykebar and Associated Hospitals  
 Stirling and Clackmannan Hospitals  
 Falkirk and District Hospitals  
 Bellsdyke Hospital

## EVIDENCE WAS ALSO RECEIVED FROM:

Ancillary Staffs Council, Trade Union Side (Whitley Council for the Health Services)  
 \*Association of Scottish Hospital Matrons  
 \*British Red Cross Society (Scottish Branch)  
 \*British Medical Association (Scottish Council)  
 Confederation of Health Service Employees (Scottish Region)  
 †Mr W. Drummond, M.B.E., F.R.C.S.  
 \*Institute of Hospital Administrators (Scottish Division)  
 †Dr W. M. Jamieson, M.D., F.R.C.P.E., D.P.H.  
 \*Joint Consultants Committee (Scotland)  
 \*Mental Welfare Commission  
 †Mr George Murdoch, F.R.C.S.  
 Dr R. Lees, M.D., F.R.C.P.E.  
 \*National Association for the Welfare of Children in Hospital (Edinburgh and Glasgow Branches)  
 \*National and Local Government Officers Association  
 †Dr J. M. Proctor  
 \*Royal College of Midwives (Scottish Council)  
 \*Royal College of Nursing (Scottish Board)  
 \*Dr C. B. S. Schofield, M.D., F.R.C.P.E.  
 †Miss M. E. Scholes  
 \*Scottish Trades Union Congress  
 \*Scottish Association for Improvements in Maternity Services  
 \*Scottish Association of Medical Administrators  
 \*Scottish Women's Rural Institute  
 †Five Ward Sisters and one Charge Nurse nominated by the Royal College of Nursing and the Royal College of Midwives  
 †Dr Cameron Weymes, T.D., M.D., M.R.C.P.(G.), D.P.H.

## APPENDIX IV

### Research and Intelligence Unit Inquiry

This appendix contains a brief summary of the aims and methods of the inquiry. A full report on the inquiry will be published in the series of Scottish Health Service Studies and copies of this will be available on request from the Research and Intelligence Unit, Scottish Home and Health Department, 79 Lauriston Place, Edinburgh. EH3 9HZ.

1. The inquiry was undertaken by the Research and Intelligence Unit of the Scottish Home and Health Department at the request of the working party to assist them by providing evidence in the form of information about the patients' point of view. It was agreed with the working party that the inquiry would be primarily concerned with

communications between patient and staff in regard to suggestions and complaints in hospitals, and would explore the following areas:

- (a) the extent to which patients claimed to have discussed their comments with the staff;
- (b) the persons in hospital with whom discussion of comments took place;
- (c) the factors which prevented or inhibited patients from discussing their comments with the staff;
- (d) patients' knowledge of the existing procedures for dealing with comments;
- (e) patients' ideas about the methods and persons thought best in theory for dealing with comments.

### The Population Considered

2. It was decided to interview patients in hospital. This population was chosen in preference to patients discharged from hospital, because it offered the advantages that patients were still involved in the situation about which they were being questioned and that longterm patients in general, mental and mental deficiency hospitals were also included. One possible major disadvantage of choosing patients in hospital could have been their unwillingness to speak frankly in the hospital situation; interviews conducted at the pilot stage suggested that patients were not inhibited from talking, and the findings from the inquiry appear to confirm this. Out-patients were also included in the inquiry and were interviewed in hospital.

3. A sample size of 1,000 in-patients was considered adequate for the inquiry. A quarter of the sample was allocated to mental and mental deficiency hospitals, and the remainder to general hospitals. General hospitals were grouped into three strata and the 750 interviews were divided equally between these, that is, 250 to each stratum. These strata were defined on the basis of factors which seemed likely to influence communications, i.e. length of stay, and information given to patients. They were:

- (a) hospitals giving patients written information specifying the person(s) in the hospital to whom any comments should be made;
  - (b) short-stay hospitals
  - (c) long-stay hospitals
- } not giving information to patients.

Hospitals in group (a) could not be split by length of stay as there were insufficient long-stay hospitals giving such information to form a separate stratum.

4. Sampling was by a three-stage random process in which hospitals, then beds, and finally patients were selected. The selection of hospitals was on the basis of a unit of ten interviews and 100 selections were therefore made at the first stage. Hospitals could be chosen more than once, and 75 were actually selected. In most hospitals ten interviews were carried out. The hospitals selected provided details of staffed beds broken down by wards; these were numbered, and selection of beds was by a random number process. A system was devised which enabled hospitals to identify the beds selected. The number of beds selected at this stage was in excess of the number of interviews required because of the expected wastage from this list.

5. A final stage of selection occurred within the hospital, and consisted of the identification of patients eligible for inclusion. Not all beds selected contained a patient who could be interviewed on the day appointed (some beds were empty). The final list of patients for interview was made up by considering the beds for inclusion, in the order in which they had been selected. When a bed or patient was ineligible for inclusion, substitution was always by the next available patient on the list, thus preserving the random nature of the sample.

6. All interviews were carried out by research staff of the Unit, and a structured questionnaire was used which was identical for all in-patients. Patients eligible for interview were given in advance a letter about the inquiry in order to give them some

chance to think of what they would like to say. This letter made it clear that the inquiry was being conducted independently of the hospital authorities, and interviewers also stressed the anonymity of response and made it plain that no names were recorded on the interview schedules. To provide a structured framework for response, the letter listed the various aspects of hospital life about which patients had been found to make complaint and invited patients to comment on these if they wished to do so, at the same time making it clear that they were entirely free not to comment. None of these topics was raised in the questionnaire and the selection of topics was left entirely to the patient. Most patients were quite happy to take part and appeared willing to be frank and to talk freely.

### **Out-Patients**

7. This part of the inquiry was confined to short-stay hospitals with 100 or more beds, because relatively little out-patient activity took place in other hospitals. It was decided to use hospitals selected for the in-patient sample as a basis for interviews and to carry out one half-day's interviewing for each unit selected for the main sample; the aim was to see as many patients as possible in the time available. Patients were normally seen as they left the clinic.

### **The Population Seen**

8. Interviews were successfully carried out with 937 in-patients and with 410 out-patients. The shortfall in the in-patient sample was due mainly to two mental hospitals which expressed a wish not to take part in the inquiry. Only seven in-patients declined to take part in the inquiry, but the sample was also short in respect of 14 interviews for children; particular difficulty was experienced in contacting parents of children selected in the sample.

9. As expected many patients were found to be ineligible for inclusion in the inquiry. Among these were patients unable to take part because they were too ill, too deaf, confused, unable to talk, not available on the day (e.g. because of operation, absence, or isolation), and certain other minor categories including hospital staff. Patients who had been in hospital less than five days were deliberately excluded to allow greater representation of those who would have had more opportunity for reflection on the matters being put to them.

### **The Representativeness of the Sample**

10. Overall 44 per cent of patients who were drawn in the sample for general hospitals were considered ineligible for interview, for one of the reasons outlined in paragraph 9 above; in mental and mental deficiency hospitals 49 per cent of patients drawn were excluded. The inquiry might thus appear to have succeeded in presenting the views of only about 50 per cent of the hospital population, but to some extent the views expressed by those patients who were interviewed can be considered as representative of patients who were not eligible for inclusion. The conditions for which patients were excluded from the inquiry on the day of interview were not, in most cases, immutable. Patients move in and out of those groups, and in so far as they may move into the group of eligible patients then they may be considered as being represented by these. For instance, many of the patients found at the time to have been in hospital for less than five days would remain until their length of stay was five days or more; thus only those both admitted and discharged within four days were effectively excluded. By the same argument, patients who were unavailable on the day because of operation or treatment would move out of these categories, and might have been included if interviewing had fallen on another day. Without doubt many of those patients with whom interviews were successfully completed would, at some time in their stay, move into an ineligible category and might have been excluded if interviewing had taken place on a different day. Thus the distinction between eligible and ineligible patients was not

a difference in kind but a difference in state which would change over time. These considerations applied not only to those patients who were too ill, or undergoing treatment, but also to some of the mentally confused, many of whom moved in and out of confused states. Thus many patients who were ineligible on the day might be considered as represented by those who were eligible on the day and were interviewed. Patients effectively excluded from the sample therefore comprise, in addition to those discharged within four days, those physically incapable of communication, and the minor categories such as staff of the hospital.

11. No figures are available showing the way in which patients move in and out of these various categories, and it is not possible to estimate the proportion of the patient population which is represented by those patients interviewed. Nevertheless, this is undoubtedly considerably in excess of the 50 per cent who were considered eligible.

12. At all stages of the inquiry selection was on a random basis, and those patients interviewed may be considered as an unbiased sample of the larger hospital population.

## APPENDIX V

### **Suggested Paragraph for Inclusion in Information Booklets for In-Patients**

We suggest that the paragraph in information booklets concerning suggestions and complaints should be worded along the following lines:

#### **"Suggestions and Complaints**

Although hospital staff do their best to provide a good service, we know that sometimes patients (or their relatives) may not be fully satisfied. If you have any suggestions for improvement in the service or any complaints, you should speak to the ward sister about them at the first opportunity, even though you may think that the matter does not really concern her. It is one of the duties of the ward sister to listen to suggestions and complaints, and if she cannot deal with them herself, to pass them on to the correct person. The ward sister will discuss the matter with you and will normally make a written record of the details; if you like you may insist on the matter being recorded.

The best thing to do is to speak to the ward sister, but if for some reason you do not want to, or if you are not satisfied with what has been done about your suggestion or complaint, you (or someone on your behalf) should write a note<sup>(1)</sup> giving brief details of the matter as soon as you can, making sure that the letter is signed, and send it to . . . . . (title and full address). There is no need to give full details; in fact, if you wish you can instead write to . . . . . (title) and ask him to come and see you".

### **Suggested Notice for Out-Patient Departments**

We suggest that the notice concerning suggestions and complaints to be posted in out-patient departments should be worded along the following lines:

#### **"Suggestions and Complaints**

If you have any suggestions or complaints, please speak to the sister in charge<sup>(2)</sup> about them. Further details about the procedure for dealing with suggestions and complaints are given on the back of your Appointments Card."

(1) Hospitals using a tear-off portion in information booklets will require to amend the paragraph accordingly.

(2) Where there is no sister in charge of the department or where she is not the appropriate person, the title of the correct person should be substituted, e.g., "superintendent radiographer", "superintendent physiotherapist", etc.

### **Suggested Paragraph on the Back of Appointments Card for Out-Patients**

We suggest that the paragraph on the back of Appointments Cards concerning suggestions and complaints should be worded along the following lines:

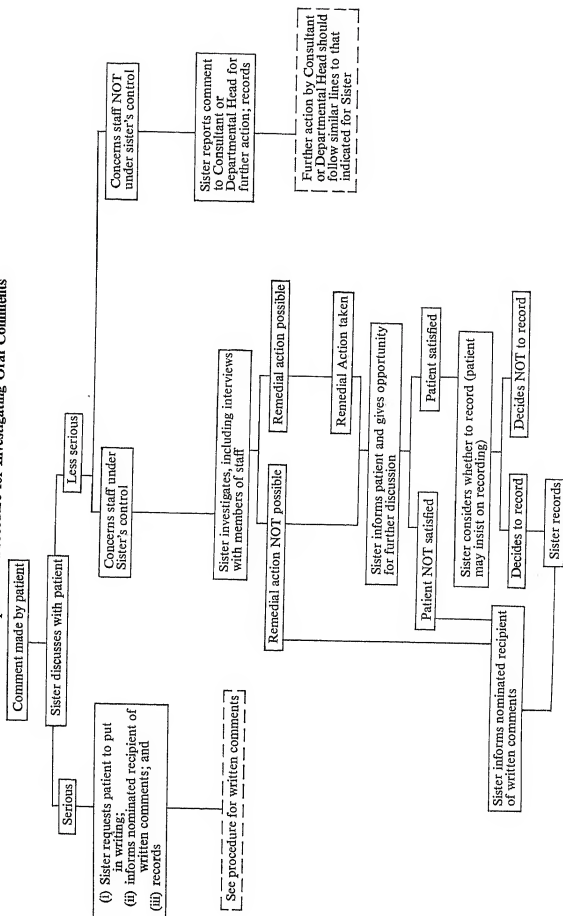
#### **“Suggestions and Complaints**

If you have any suggestions or complaints, you should speak to the sister or other person in charge of the department or write to . . . . . (title and full address) giving brief details of the matter, making sure that the letter is signed. Instead, if you prefer, you can write to . . . . . (title) saying that you want to see him.”

These paragraphs may have to be amended slightly in the case of mental hospitals to take account of the role of the Mental Welfare Commission, particularly with reference to the role of the Commission in dealing with complaints.

# APPENDIX VI

## Steps in the Procedure for Investigating Oral Comments



## Steps in the Procedure for Investigating Written Comments

